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LETTERS TO THE EDITOR

Conditions of Student Protest

TO THE EDITOR:

Freedman and Freedman in their opinion entitled "Responding to Student Protest" in the October 1968 issue of the JOURNAL have pointed up the conditions of which student protests are only a symptom. They have gone beyond limited consideration of the internal psychology of the student and placed the mechanism of the psychology of protest within the framework of the culture and social structure in which it lives.

They have pointed up: (1) that student protest is an expression of despair in an atmosphere of "not being listened to," (2) that students are taught to appreciate a democratic society, but this same society has not implemented opportunities for democratic action, (3) that this failure leads to blaming students for the ensuing trouble (a common defensive mechanism), (4) that, therefore, there is insufficient serious effort made to overcome the failure through collaborative work between student and university leaders. Yet such collaborative effort is of necessity.

The Freedman article, in contradistinction to the one by Levitt and Rubenstein [July 1968 JOURNAL], points up: (1) that considering student protest as a "children's crusade" is an avoidance of the real issues, (2) that it conveys an attitude of disrespect for student opinion, which then is covered by professional psychologic terminology, (3) that such disrespect breeds further alienation between university and student.

I would like to add one thought about the question "why is the protest aimed at the university?" One rationally makes one's protest where one lives. The university has possibly the largest concentration of youths who are likely to give critical thought to the direction and development of our social ways. A major if not the major portion of their lives is involved in and affected by

the university, its rules and its structure. The student, therefore, perceives the issues most clearly as expressed in university life and is most likely to focus his action upon it.

*Leonard Gold, M.D.
New York, N.Y.*

What's In It for Children?

TO THE EDITOR:

It has been said that the child is father to the man. If so, it would follow that our attempts to produce a great society for man would have a better chance of success if we marshalled our efforts initially around children. Contrary to this logic, however, it would seem that our American society has been determined to either prove this adage wrong or masochistically do it the hard way.

A review of the progress that our nation has made in the direction of producing a great society, at least until recently, would reveal the validity of my belief that we certainly have been doing it the hard way.

At the time of our decision to provide needed legislation for enabling the formerly dependent and neglected child to remain with his mother, an act so necessary for constructive growth and development of children, did we really not know that most of these mothers needed as much mothering as did their children? Knowing this, and I believe we did, did we provide the necessary support for her to have some chance of succeeding in her role as mother? Did we provide help to her, as we are now contemplating, in the form of increased social services, child development centers, child care workers, more comprehensive health services, educational services? Should we have been surprised at the outcome—children neglected, abused, in poor health, understimulated or overstimulated, and children hopeless about their future?

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OPINION

Disadvantages of "The Disadvantaged Child"

It is time for the psychiatric community to take a closer look at "the disadvantaged child." This concept may have outlived its usefulness. During the past decade it served a positive function in focusing attention on the potentially noxious effects of environmental deprivation on the psychological and educational development of children. But the term "disadvantaged child" has come to be applied as an all-purpose label blurring the issues it was intended to sharpen.

To avoid being misunderstood, let me emphasize my high regard for the many excellent studies that have been reported on this subject in recent years. These studies have reflected a vital awareness that the conditions of life in economically blighted areas generate

special problems for the children who live in them. Professional workers in the fields of mental health and education have become increasingly concerned about fulfilling their responsibilities to these children.

But our efforts will be hampered if we fail to guard against certain pitfalls. One of these is the tendency to recommend interventions before determining the exact nature of the problem. In order to change the course of events constructively for children brought up in slums, ghettos, and other poverty-burdened areas, we must be clear about the meaning of "disadvantaged."

The trouble is that the term is so often used in a global way. When we speak of "the disadvantaged child" we tend to assume a homogeneous group embracing all lower-class youngsters. This lack of differentiation produces not a diagnostic tool but a stereotype. To be sure, there is a sense in which all children in the lower socioeconomic group are indeed handicapped. The penalties of poverty are not illusory. Among lower-class families the incidence of malnutrition, prematurity, and brain damage is higher than among economically priv-

EDITOR'S NOTE: *Opinions are invited by the Editor from members of the Editorial Board and of the Board of Directors and from other Fellows of the Association. Each represents the viewpoint of its writer on a controversial issue in the field. Responses from readers to these opinions will be published in the Letters to the Editor column.*

ileged families. Nevertheless, it would be a mistake to neglect the wide range of variations within the impoverished group even in respect to such matters as diet.

Outside of economic categories, we are on uncertain ground. We have as yet little information about the psychological impact of poverty on different children. There is not a uniform "mark of oppression." As Robert Coles has vividly shown in *Children of Crisis*, the so-called disadvantaged youngster may show strengths that are beclouded by the stereotype. It is well known that some children raised under conditions that are presumed to produce cognitive deficiencies, motivational impairment, and defective self-images do achieve success in academic functioning and cope in a competent fashion with the challenges in their lives.

The children in the "disadvantaged" group represent many different cultural backgrounds. They exhibit a host of medical, neurological, perceptual, intellectual, and psychological characteristics that vary widely. It is therefore essential that in gathering descriptive behavioral data we distinguish between capacities that reflect neurological deficit from those that reflect class identity; we must separate perceptual ability from attentional habits that are culturally determined; we need to identify the difference between intellectual capacity and verbal patterns characteristic of a group.

The stereotype, no matter how benevolently intended, ignores the rich diversity of individuals within a group. And psychiatric measures, when they are needed, cannot be usefully planned if they are directed toward a stereotype. To assess any individual child it is es-

sential to know *both* the group characteristics and the variations within the group.

Unfortunately, however, there is a lack of systematic criteria for categorizing group behavioral norms for children brought up in specific socioeconomic and cultural settings. In psychiatry, the uncritical application of white middle-class norms to lower-class children of Negro, Puerto Rican, and other cultural backgrounds has often resulted in significant errors of diagnosis and therapy. In the field of education, it is clearly important for the teacher to distinguish those behavioral deviations that represent functional adaptive responses to the disadvantaged child's life experiences from those which represent idiosyncratic maladaptive patterns of psychopathology.

Thus, there is an urgent need for a body of studies that will concretely examine the behavioral characteristics of lower-class children. Such studies must take a number of considerations into account:

1. Marked differences in family structure, parental practices and attitudes, and ethnic background may exert significantly different influences on psychological development.

2. Behavioral functioning may be influenced by levels of general health, neurological intactness, and perceptual and intellectual functioning.

3. Individual differences in temperamental characteristics and behavioral style may influence the child's social development.

4. The typical behavior exhibited by a lower-class child may vary significantly with the nature of the environmental situation or demand. For exam-

ple, the child may behave one way in the familiar intragroup situation and quite differently in an alien, threatening environment.

5. Patterns of emotional expressiveness, language usage, and style of social functioning may be different in various cultural groups.

One cannot overemphasize the importance of cultural evaluation in psychiatric diagnosis and treatment. Some 15 years ago I noted that "an evaluation of the healthy or morbid psychological aspects of an individual can be made only in terms of what is appropriate and effective functioning within the specific cultural milieu." * This is as true today as it was in 1953.

Today, however, it has become more imperative than ever to challenge the tendency of a dominant group to impose

its preferred style on other groups. Some persons of good will make the mistake of refusing to accept the fact of differences, as if all differences must be categorized as higher or lower on a scale of absolute worthiness. Nevertheless, there are differences in children's behavior originating in genetic endowment, temperamental qualities, cultural background, socioeconomic status, and individual experience.

For proper carrying out of psychiatric responsibility it is necessary to be familiar with these differences, not only among groups but also among individuals within groups. Failure to take such differences into account leads to unwise and ineffective interventions. Because the concept of "the disadvantaged child" masks a wide range of attributes and levels of functioning, its value is to be questioned.

* S. Chess, K. B. Clark, and A. Thomas. "The Importance of Cultural Evaluation in Psychiatric Diagnosis and Treatment," *Psychiatric Quarterly*, January 1953.

*Stella Chess, M.D.
former member, Editorial Board*

THEORY AND REVIEW

A Tract for the Times: SOME SOCIOBIOLOGIC ASPECTS OF SCIENCE, RACE, AND RACISM

Benjamin Pasamanick, M.D.

Associate Commissioner, New York State Department of Mental Hygiene
New York, New York

Despite 75 years of research on Negro intelligence, the question of racial difference will not die. This paper reviews the confused and confusing issues involved.

As the lukewarm skirmish against poverty gives promise of turning into a hot war of rebellion for justice and equality, the fifth estate—science—rides precipitously into the fray, frequently to add confusion and to protect and give comfort to the establishment.

I would like to take as the thesis for my tract, the 1967 meeting of the National Academy of Sciences, where the smoldering question (implicit or explicit) of Negro inferiority exploded anew. This time the protagonists were Shockley, the Nobel Prize winner for transistor work; Kennedy of Florida State, sponsored by Harlow; and, finally, the Academy itself.

The tired questions at issue again were: Are Negroes genetically inferior? Would an improved environment really improve their social functioning? Are scientists inhibited from investigating these problems? Etc. Etc. What was offered was a new, definitive test, which on further scrutiny turned out to be neither new nor definitive.

Kennedy⁴ mentioned very briefly the 75 years of massive studies on Negro intelligence, stating that if there could be individual differences in some characteristics, there could be race differences in intelligence. He pointed to a 20% IQ difference between Negroes and whites in the Southeastern states,

This paper was Dr. Pasamanick's presidential address to the American Psychopathological Association, delivered at its annual meeting in New York on February 16, 1968.

narrowed to 10% by so-called preschool "cultural enrichment" programs. The fact that Negro infants in those states were indistinguishable from white infants for the first two years, he said, "challenges the hypothesis of Pasamanick that one of the major effects of cultural deprivation and its poor prenatal nutritional and medical care is the production of sickly, underweight, and often premature infants who begin life at an inferior level of 'intelligence.'" But he then went on to state that infant tests do not predict school-age test performance anyway.

The test suggested by Kennedy involved placing illegitimately pregnant Negro girls in maternity homes with good prenatal care and diet and then placing their offspring in middle-class Negro homes—using as controls lower-class Negro and white infants left in their biological environment.

But he asked the obvious question himself—Why do such a study "when intelligence tests themselves may not be the most sensitive instrument by which to study the effect of genetics on performance"? Part of his reply was a plea "simply to open the field of inquiry such that honest investigators may make careful study of racial differences in the hope that unique racial factors may be found which might well go undiscovered by default and thus to keep the concept of racial differences in intelligence as an open question." He did stress that as far as he knew "there is no convincing evidence that there are any racial differences in intellectual abilities that are based upon genetic factors."

Some months later a letter³ commenting on Kennedy's paper appeared in *Science* pointing out that, "Some of the effects of a poor prenatal environ-

ment may not show themselves clearly until relatively complex intellectual tasks are presented later in the child's life." The writer pointed to our data indicating "that lower socioeconomic status is associated with dietary deficiencies during pregnancy, lack of adequate medical care during pregnancy and delivery, prematurity, greater maternal and infant mortality" and a higher incidence of maternal complications in nonwhite mothers attributable to their socioeconomic status. Further, that nutrition during pregnancy was associated with intellectual performance in offspring and that the mother's nutritional history and other aspects of her health history even prior to the conception of the child may influence the status of the child. The final point made was that the "attributing to heredity any IQ differences (remaining) on the basis of such studies (as Kennedy's) could hardly be justified, (i) because not all of the known relevant environmental variables would have been controlled, and (ii) because knowledge of the relevant environmental variables cannot be assumed to be complete."

To this Kennedy replied⁵ "that when . . . mothers are given adequate prenatal care, even as late as the second trimester of pregnancy, the findings of Pasamanick do not hold. That is, if the mothers are given a vitamin and dietary supplement and adequate prenatal care, the Negro children, far from being born at a physical disadvantage, are born instead in what appears to be a superior position, as far as the general measures of intellectual and physical health are concerned. Although Pasamanick's study does indeed call attention to the necessity of controlling the prenatal environment, his findings are not consistent

with those of almost any well-baby clinic with reports on Negro children born with hospital prenatal care. His findings evidently result from a combination of factors related to extreme poverty in a large city slum with very poor prenatal care."

Kennedy then proposed that "mothers could be eliminated [from his study] if they showed any evidence that massive deprivation had occurred during the first trimester." He did not, however, reply to the issue of preconceptional malnutrition and disease related to socioeconomic variables, which has indeed been heavily implicated in reproductive casualty by Baird in Aberdeen.

Kennedy did acknowledge that "the study might not be definitive, particularly if significant differences between the experimental and control groups were obtained, . . . given the use of the null hypothesis."

Before continuing with the next episode in the narrative, I would like to clarify as briefly as possible some of the confused and confusing issues raised in the foregoing and to discuss some biologic factors involved.

Kennedy stated that in the Southeast Negro infants during their first two years progress behaviorally at rates no different from those seen in whites. It is amusing to note that we were the first to demonstrate this more than two decades ago on what was probably a representative, if small, New Haven sample.¹⁰ The New Haven findings were replicated twice on much larger and more obviously representative samples in Baltimore and Columbus.⁹

These are not irrelevant measurements, unpredictable of school-age functioning as Kennedy says. On the con-

trary, we and others have demonstrated repeatedly that the prediction of performance on standard intelligence tests given children seven years after testing them as infants is at least as good as the prediction of performance on the same tests given children seven years apart within their school-age period. This is only further proof that the patterns of behavioral development during infancy contain all the precursor ingredients of later behavior, and that any deficiencies in conduction time, perception, central nervous system integration, motor output, etc. can be discovered in infancy. Indeed, we have shown the prediction of such defects to be even better than the prediction of intellectual performance.⁹

It is true that we have found a greater incidence of severe damage in Negro infants related to perinatal events, but this has been insufficient, during infancy, to influence the *mean* quotients of our Negro samples. As a consequence, again contrary to Kennedy, we have never placed any great weight upon prenatal damage as a cause of Negro group intellectual dysfunction during the school years. We had some evidence on the basis of retrospective studies that prenatal damage disorganized all aspects of behavioral functioning, including cognition, but it wasn't until our recent analysis of longitudinal data that we were prepared to elucidate the seemingly paradoxical findings that prenatal damage results in no differences in mean quotients during infancy and yet should be considered as one of the variables involved in school-age differences.

First, I should point out that damaged children were a not inconsiderable fraction of our total. Approximately one eighth of the infants exhibited objective,

reliable indices of brain damage. We now know these indices to be valid, for seven years later we found 90% of these same children, no matter what their race or economic status, to differentiate clearly on a battery of tests of perceptual, integrational, and motor items. But what we had not fully anticipated was how socioeconomic status, again irrespective of race, would differentially affect these injured children. The group as a whole fell from its early promise of intellectual potential, but it was the children in middle and lower socioeconomic thirds of the group who contributed most to the decline and, as might have been anticipated, largely the children in the lower third who fell most precipitously.

Let us examine a bit more closely the probable course of events leading to this decline and fall. The common explanation offered for the poor showing of lower-class children is lack of stimulation, for which the paradigm is the animal isolation experiments. While this might hold for children in the old orphan asylums, nothing could be less descriptive of the slum child's environment, living as he does in crowded quarters and constantly bombarded by sensory stimuli of all modalities—blaring radios and television sets, extremes of heat and cold, surrounded by active adults and children frequently in disorganized and confusing array—difficult even for the intact child or adult to integrate or inhibit. The injured child with impaired inhibitory, attentional, and integrative capacities responds with aphasia, autism, and extremes of psychomotor excitation, making it difficult, if not impossible, to mature successfully. We have demonstrated, in addition, that he contributes to the further disorganiza-

tion of his own environment and is subject to repeated illnesses and hospitalizations, so that it is not surprising that we end with a schoolchild with a low IQ, demoralized by constant failure and a distinct handicap to his ghetto schoolmates.

I do not want to overemphasize the contribution brain damage makes to the decline of the group mean IQ but rather to indicate its cost to group functioning and what the needs are for individualized care. But I will return to it after discussing another biologic variable which we can now begin to place in a more precise context.

In our first longitudinal New Haven study we found that a number of commonly implicated social and demographic variables had played no role in influencing infant development. Physical growth was the only variable found to be significantly related to performance. Those infants below the median on height and weight curves, even by 40 weeks of age, were already significantly lower in intellectual potential than those above. Nevertheless, the group *as a whole* had growth curves similar to the best white rates, and at school age had IQs equal to whites. (It is true that those living in segregated areas and attending segregated schools were lower than the others.) We felt justified in assuming the probability of a causal relationship between nutritional intake before and after birth, in turn related to full employment and rationing during the war years, with consequent satisfactory behavioral progress.

Once again, in Baltimore we confirmed precisely the same relationship of physical growth to performance in the Negro group. But two, probably not unrelated, differences from the New

Haven findings struck us: first, that the Negro weight curves, even for full-term children, were significantly lower than white curves; second, that by three years of age the Negroes were also falling behind intellectually. A third, most telling finding, was the discovery that the white children did not have this relationship of low physical growth curves to low performance.

We can now, with support from other studies, begin to offer a simple explanation for these seemingly disparate findings. Amongst the whites, at least in Baltimore, physical growth patterns appear to be largely reflections of inherited physique rather than related to nutritional intake; in large measure, and as a group, whites are above that threshold where dietary differences during childhood play a significant role. The Negroes, on the other hand, perched precariously on the low rungs of the economic ladder, are significantly lower than whites in physical growth, and those sufficiently below the threshold exhibit the intellectual consequences of nutritional deprivation, primarily of protein and vitamins. (One can only imagine the devastation occurring in grossly undernourished populations abroad.)

We can also, at this time, begin to outline the probable biochemical and physiologic mechanisms involved. It seems clear that either RNA and/or protein synthesis in the neuron is involved in long-term memory and learning and consequently in behavioral and intellectual functioning.¹³ Chronic or intermittent malnutrition could affect this synthesis and thereby have recurrent or permanent effects leading to disorganization or delay in the complex of reciprocal interweaving of developmental

patterns which we term intellectual maturation. These effects would be greatest during fetal life, leading to measurable neurologic impairment, with lesser interference during childhood, impairing only intellectual growth in most cases.

We can now begin to fit these two biologic variables of brain damage and malnutrition into the highly interrelated complex of biologic factors (there are other variables such as infection, immunologic responses, toxic substances, etc.) and in turn into the matrix of biopsychosocial factors which cause racial differences in intelligence. And the biologic variables are probably not the weightiest contributors to malfunction. All we need and can do is list some of the others: the powerlessness, the recurrent blasted hopes, the shame, the fear, the anger, the dirt, the noise, the poor health care, disease, strife, frustration, hunger, idleness, hard work, disorganization, lack of stimulation and dystimulation, and on, and on, and on.

And in how much dysfunction does this seemingly endless spiral result? In Baltimore, where one of the worst ghettos in the country exists, at six years of age the Negro children are only 10% behind the whites (and this on a test, the Stanford-Binet, that is strongly biased in its contents against lower-class children). (This is in stark contrast to the 20% Kennedy reports in Southeast U. S., indicating that, bad as conditions are in the cities, they are still worse in the South, particularly in the rural areas.) Even further, when the Negroes as a whole are compared to the lower socioeconomic half of the Baltimore whites, they are only 5% behind and, were it possible to equate the socio-

economic conditions, there is no doubt there would be no significant differences at all.

In the face of what these children must contend with, day in and day out, and the significant but relatively small differences which become smaller or disappear with even minor improvement in their lot, how can one speak of innate racial inferiority? I can only stand in awe of man's stamina and his resilience in response to the continuous onslaught upon his functioning. I state hesitantly and, probably with some bias, that I believe whites could do as well under the same circumstances.

I would maintain that the successive approximations made to ultimate knowledge of group differences in intellectual functioning make Negro innate inferiority exceedingly implausible and that at this time we know enough of what must be done to erase this infamy. (It is of no little interest that in that long, sad document, the 1968 President's State of the Union message, proposing some crumbs of health care, the heaviest emphasis was on maternal and child health.)

What we can say quite clearly at this time is that, when a sample of Negroes approaches sociocultural comparability to a white sample (and I must add that, because of centuries of discrimination, even under the best of circumstances no precise comparability is currently possible), the Negroes become comparable to the whites in all important aspects—infant and maternal mortality, physical growth, morbidity, and intellectual performance. However, the common reply to this observation is that these samples are biased, containing only individuals at the upper end of the curve of capacity. Such circular polemics lead inevitably to the conclusion that unless and until

the Negro achieves full social and economic equality in our society, the definitive test of his capacity is not possible. The challenge to those eager and determined inquirers into scientific truth then becomes one of turning all the strength of their efforts and determination into achieving the type of society in which the definitive test is possible. It is at this point that the crucial decision arises and must be made. Until they accept this challenge we must doubt their intentions and, indeed, their scientific and social integrity.

But I greatly fear that the most common response is that Negroes, because of their capacities, could not reach social and economic equality even if given the opportunity. This is, of course, to prejudge the outcome, and becomes the basis for the self-fulfilling prejudice with which we have been contending. The more ingenious reply is that it would take too long, be too difficult. All the more reason to hasten and devote all our energies to the task, instead of diverting them largely or wholly to trivial investigations of racial differences which lead us back into a meaningless circle of inconclusiveness.

In the light of this analysis, Shockley's¹² call for public debate on Carleton Putnam's racist ideas becomes, indeed, shocking. As for his hoary argument, as old as Galton, that the mean IQ of the population is declining because the genetically inferior families have more children, it can be dismissed along with a whole farrago of nonsense, as it was by the entire genetics department at his university who termed it "pseudoscientific" and falling "between mischief and malice".¹ Studies made in Britain over decades have indicated that, rather than

declining, IQs have risen as have physical growth curves. The British, with far less wealth and productive capacity than we, have achieved a lower infant mortality, lower prematurity and complications of pregnancy rates, and a rising intellectual potential merely by a more equitable distribution of their goods and an approach to a better system of social services.

Why do we keep harping on the subject? Why do we respond automatically to every prod into the festering gangrene? Certainly we have little hope of convincing the prejudiced or changing the racist.

Donald Campbell² in his essay on stereotyping points out that, "In southern legislatures in the last 100 years, the alleged intellectual inferiority of Negroes has played an important role. Removing the belief that Negroes are inferior would not, however, remove the hostility, although it would change the content of the stereotype. Had the World War I test results showing northern Negroes to be more intelligent than southern whites been effectively publicized in the South, opportunistic hostility could certainly have created an image of the northern Negro carpetbagger whose opprobrious traits included shrewdness, trickiness and egg-headed intellectuality. Remedial education in race relations focused on denying or disproving stereotypes implicitly accepts the prejudiced ingroupers' causal conception rather than the social scientists' and is undermined where actual group differences are found."

I do not wholly agree with this last, but why take the risk? Let me take my cue from the next scene in our tragic comedy.

In November 1967 *Science*, reporting

on William Shockley's call for research on the effects of heredity and environment on intelligence, indicated that his call had been uncomfortable for the National Academy of Sciences, adding up "to a loaded question that might be destructively exploited by racists if the Academy even ratified it as the right question".¹¹ And, in reaction, the Academy's president presented its Council's response in a long statement prepared with the assistance of several eminent geneticists.⁸

The statement began with the nature of certain questions being asked, went on to the difficulties involved in such investigations, and then said on one hand this and on the other hand that. But amongst its conclusions, which were also hedged, it stated:

... we question the *social urgency* of a greatly enhanced program to measure the heritability of complex intellectual and emotional factors.

Likewise, we question the social urgency of a crash program to measure genetic differences in intellectual and emotional traits between racial groups. In the first place, if the traits are at all complex, the results of such research are almost certain to be inconclusive. In the second place, it is not clear that major social decisions depend on such information.⁸

Wars, past and present, have stimulated research which has proved of benefit to mankind but which cannot, under any circumstances, justify the waging of war. Similarly the centuries-old war against injustice and inequality has taught us much about life processes and human functioning, certainly enough to end most of this strife. The social urgency is to do that which must be done to end the strife, not to ascertain what should be done. And we all know how great is the urgency.

To call, at this time, for more research on racial differences in intelligence is

an exercise in futility and callousness. It is analagous to calling in the midst of a slum fire for research on the relationship of racial differences in pigmentation to resistance to burns. We are on the verge of a holocaust and the research has been done.

The concern which drove the National Academy to issue its statement is a very real one. The *Iron Mountain* mentality of brutal repression of demands for a decent life has been endemic in American society since its inception, and is spreading as one of the reactions to our present crisis. We must not ignore it or its concomitant desperate search for scapegoats. The Indian, the Negro, the alien have served in the past, and racism has been its base.

It is sickening to recall that one of the items in the indictment of the Jews drawn up in *Mein Kampf* was that of their defense of racial and ethnic groups and their opposition to the Nazi doctrine of the simian character of the Negro. This doctrine has served its purpose well in justifying slavery and second-class citizenship for the Negro.

Science in its comments upon Shockley hints at another rationalization, "Or will genetic inheritance produce such a low social capacity index that most will perform at frustratingly low social levels?"¹¹ Mechanization and new methods have made the Negro superfluous in the rural South, condemning him to slow starvation or refugee status in the North. Is there now a suggestion that automation and urban life which require skilled labor and high social capacity indices have made the Negro superfluous in our society, calling for "apartheid" or even "a final solution" of the Negro problem?

Might it be these implications which

the Academy Council had in mind, recalling our genocidal efforts upon the American Indian and the more recent cry to bomb a small country "into the Stone Age," when it issued its statement?

We recoil in horror—and in this reaction lies our hope. We are in a crisis—urban, national, global. We, as a society, have striven frantically for control over all animate and inanimate matter in this world, the moon, the planets, and the stars with a system of values based upon self-interest, dead-ending with power as an ultimate good. We have evaded the self-confrontation necessary to reorder our values to achieve a true community and a just society. We can evade it no longer and, uncomfortable as it may be, it is good that it is so.

John Gardner, voicing the concern of all humane people, has said that there are two overriding, immediate items on the agenda of American society—a decent, equal place for the Negro, and peace. The two are, of course, *totally interdependent*. The wherewithal for the jobs, housing, education, health care, and other ingredients of a dignified existence can only come from those tremendous resources now allocated to destruction.

Half of the 160 billions of dollars the world pours into war and preparation for war is expended by our country. This is in violent contrast to the 7 billions from all nations going towards aid to the poverty-ridden countries, for which our contribution continues to fall, now ranking us fifth in proportion to our production. What a world this could be if we reversed these expenditures.

This jeremiad, I know, is only one of many now coming at you from all quarters and indicating the universal shock of recognition of our problem.

They are the inevitable first reactions upon which we must build together a reordering of our values and reallocation of our resources. To remain quiet is to lapse into the cynicism or apathy which can follow upon the darkness confronting us. Gunnar Myrdal, who described the American dilemma of inconsistencies within the American dream, returned last year after two decades to offer his final warning against stupid optimism. We must operate from the most realistic view of things as they are and then go forward, because *blind* retreat is no longer possible.

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THE TRIPLE CHOICE: SOCIAL, POLITICAL, CULTURAL

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Man is a multiple amphibian, living in a number of environments. Three of these are the social, the political, and the cultural. This paper points up our need to rebuild community in the social sphere, to revitalize democracy in the political sphere, to update our culture through relevant art.

In the midst of the specialized papers in this journal, I propose to stand back and take a look at the global problems that confront us; problems we face not primarily as professionals but as human beings. I will touch on three: a social problem, a political problem, and a cultural problem.

A SOCIAL PROBLEM

The gravest social problem of our time, more serious than race, more intractable than poverty, is the dissolution of community. (I except war, classifying it as a political rather than a social problem.)

By improving transport, technology has "annihilated space" and increased

man's mobility enormously. With V-TOL (Vertical Takeoff Or Landing) and supersonic flight, it is already theoretically feasible to commute anywhere on the planet—to live in Chicago, say, and work in New Delhi.

Such mobility has all but dissolved the primary groups in which man used to live. By "primary group" I mean one that envelops individual lives completely, both longitudinally—from womb to tomb—and laterally, subsuming within it all segments of the individual's life: work, play, worship, education, friendship, love, whatever. The extent to which Americans have broken out of primary groups longitudinally is evidenced by the fact that the average American now

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moves five times in the course of his life—not across the street, but across state lines—and will change kinds of work thrice. Concomitantly he has broken out of the primary community laterally by living removed from his work, schools, and churches and developing thereby separate associates for his various interests.

The consequence is that individuals today are not perceived and responded to as whole persons. Visualize a human life as a stone column. Each foot of the column's height represents a year. If we cut a cross section from the column we find pie-cut markings depicting the various aspects of the individual's life: work, play, family, worship, learning, and so on. In primary communities men were approached and known as complete columns. Today only parts of them come through to others: a pie wedge several feet high out of an actual 50 or 60 feet of rounded column.

Another way to put the point is to say that people encounter one another today not as whole persons but in one or another of their roles, "role" here meaning behavior in which what counts is *what is done* rather than *who does it*. Within roles, persons are interchangeable: any number of persons could fill the role of a mail carrier or a checkout girl without it affecting the role in the least. Don Marquis once remarked that no number of five-year plans adds up to the millennium. We can paraphrase this and say that no number of roles adds up to a complete person. The more we live our lives through roles, the more our selfhood idles. If we ever come to the point where we live only our roles, we shall have no selfhood at all. This prospect is

more than theoretical. When Quentin in Arthur Miller's play *After the Fall* cries out "I can't find myself!" it's no wonder. Like many in our time he has no selfhood to find.

This breakup of the primary community within which men encountered one another as whole persons, this splaying out of life into multifarious and loosely related roles wherein only segments of persons connect, accounts for much of the emptiness we feel today. I think of something a friend of mine, Leroy Rouner, said after six years of teaching in India. He had gone there schooled in the existentialist view that man's basic condition is *angst*, or anxiety. The longer he lived in India, however, the more remote and contrived this moody existentialist view began to sound until at length Rouner concluded that at best it describes Western, industrialized man, not man in general. The Indians around Rouner were living under conditions European existentialists would have found intolerable. The conditions obviously occasioned a great deal of suffering, but of that specific kind of suffering we identify as *angst* the Indians seemed to know nothing. For whenever disaster hit—crops failed, disease struck, a child died—the community, usually the caste, would close in to shore up the stricken with empathy and support. Because "for the most part men have a 'native place' where they belong and are known, where hope is enhanced by encouragement and despair eased by the knowledge that one does not stand alone. . . . India seems to produce few genuinely lost souls." *

With us lost souls abound, the chief reason being our shift from communal to fractionated, splayed existence. The

* LeRoy Rouner, "The Place of Provincialism in Theology," *Christianity and Crisis*, Feb. 7, 1966.

American family shows this shift so clearly that to look at the family is to see the shift in microcosm. The family has always been the heart of the community. Today it has become temporally shorter and spatially less compact, more decentralized. It is temporally shorter in two ways. It is shorter in the obvious sense of not holding together as long—Virginia Satir has proposed that with divorce rates running as they are, it would accord better with reality if marriage vows were reduced to a five-year contract. But families are also shorter because geographical separation has loosened ties to grandparents, leaving families bridging only two generations where formerly they bridged three. These looser grips on time are paralleled by the family's looser grip on space. With work, education, recreation, and worship removed from the home, the family has moved from fused existence toward becoming a point of intersection for orbits and epicycles. That this loosening of the family's hold has intensified many social problems seems clear. A recent report credits the absence of serious drug problems in France to the fact that "the French family unit, while undoubtedly looser than it was 10 or 15 years ago, remains comparatively strong. The overwhelming percentage of young, unmarried people still live at home, or if they don't, visit their parents at least several times a week."

In citing the change from communal to splayed existence as the basic social change in our time I say nothing new, but the change is so important that we need to keep reminding ourselves of it and trying to understand, ever more deeply, how it affects our lives. I have mentioned the emptiness and rootlessness it occasions; others have noted its connection with crime—which rose again

last year: 22% in cities over half-million, 16% in suburbs, 12% in rural areas. To these consequences I shall add only one other: the way community disintegration sharpens competition. The United States is, I believe, the most competitive society to have appeared in human history: see the recent graphic treatment in Norman Podhoretz's *Making It*. Konrad Lorenz in *On Aggression* considers this competitiveness with its managerial diseases, high blood pressure, renal atrophy, gastric ulcers, and torturing neuroses the most stupid product of intra-specific selection short of the wing of the Argus cock pheasant which, to please the hen, has enlarged to the point where the bird can scarcely fly and is threatened with extinction.

Why has our society become so dangerously competitive? Chiefly because it has ceased to be communal. It is in man's nature to want a place in the sun—this is a cross-cultural invariant. But in which sun? Much turns on the answer. When men lived in communities, there were as many suns as there were communities and, there being more suns, there were more places in it. But more important than this quantitative difference is the qualitative difference. Because in communities people were known as "whole persons," this could be a (if not *the*) standard of success—how well the person lived his life generally. In such communities good guys didn't finish last, not in the community's esteem. If in our society they often do finish last, it is because our society provides no forum wherein persons are regarded as wholes. Consequently their place in the sun must be secured through some part of themselves, some specific talent, skill, or acquisition: intelligence, beauty, artistic promise, power, wealth, something. To

lay the matter out propositionally, the fact that man's basic social setting has become impersonal affects competition in three ways:

1. It increases it. Whereas formerly recognition was *conferred* on the individual by the community which was, practically speaking, his entire world and of which he was an integral, fully known and accepted member, today the individual must *achieve* recognition if he is to have any. Society requires of him, as a basic test of masculinity (and increasingly femininity), proof of performance.

2. This performance must relate to an *aspect* of the individual's life rather than to its entirety; it must be in some specific field. In communal life where persons were known as wholes, they could be assessed as wholes. Where they are known in fractions this is not possible. Rewards go not to whole men, complete men, but to specific talents they evince.

3. These specific talents must have high and wide-ranging visibility. If a mathematician lived only among mathematicians, the fact that his colleagues recognized him to be brilliant in this area would be enough. But he doesn't so live. He lives with his family and in his suburban block, neither of which are overly impressed by mathematical prowess. The mathematician must have tokens of achievement that are accepted by all his groups. A handsome salary will do, or his picture frequently in the paper.

To paint the picture thus entails no romantic view of the past. Communal life must have presented many problems, more perhaps than does ours. Privacy must have been almost nonexistent, beyond which you couldn't escape from your mother-in-law if you needed to or

stake out a new life if you spoiled your first. But these were their problems; our responsibility is to ours. (1) Only loosely rooted in community, we feel more at sea, more empty, than have most men in the past. (2) We incline more to violence both because there are fewer people we care about whom such acts would disappoint and also because this is one way we can still make our lives count, and we would rather have them count for something (even destruction) than for nothing. (3) We are more driven to succeed in specific, conspicuous ways.

What the root problem calls for in the way of concrete measures I'm not sure. Community psychiatry and encounter groups look like promising leads, but nothing turns on this perception. My point is the general one: somehow community must re-form around us, and as the drift of technology is against its doing so automatically, we are going to have to work at the job more than we have thus far. For in some sense Martin Buber is right: "Man will not persist in existence if he does not persist in it as a genuine We."

A POLITICAL PROBLEM

It was technology which, by improving transportation, disrupted community, and technology is likewise responsible for the political problem I wish to identify.

Technology compounds power and the wealth that undergirds it, and (left to its own devices) it concentrates them.

Begin with wealth. It took all of human history up to the middle of this century to develop an economy—ours—capable of growing at $2\frac{1}{2}\%$ per annum. Such a growth rate, if sustained, would enable children to be roughly twice as wealthy as their parents.

Only 18 years separate us from 1950, and already one economy (the West German) has achieved a GNP * growth rate of $7\frac{1}{2}\%$ and another (the Japanese) a rate of 8%. Growth rates of this order would enable children to be six times as rich as their parents and 36 times as rich as their grandparents.

I cite these figures to point up the fact that after capital-accumulation reaches "take-off" momentum it increases geometrically, not just arithmetically. This places nations that take off early at an enormous advantage: they leave other nations not just behind but increasingly behind. The gap between them and less developed nations widens. The consequence is that if things are left to their natural course the world is going to become in the remainder of our century even more unbalanced in wealth and power than it is already. As the population explosion is centering in the have-not nations, the have nations will represent a decreasing proportion of the world's population while possessing an increasing proportion of the world's wealth and power. Pointing as this does towards a world composed of islands of affluence off a mainland of misery with a global race war a real possibility,** the situation is neither healthy nor just.

Correlative with the fact that technology compounds wealth and power is the fact that—again, left to its own devices—it concentrates these. When power meant brawn it was fairly evenly distributed; each human being counted roughly for one. Even when power meant brawn plus clubs, men possessed relatively equal portions. But the day when

the Bastille could be stormed with pitchforks is over. Today no revolution can hope to succeed unless it subverts the military and captures the media of communication.

The hope, of course, is that in democracies revolutions are not necessary because political structures keep power in the hands of the electorate. But Vietnam has made us wonder if our political channels insure either that truth gets down to us or that power rises up from us. Doubt that truth gets down to us is summarized in the phrase "the credibility gap" † and in the fact that—to cite a single instance—after 20 years the basic official formulation of our nation's "containment doctrine" still remains classified. Doubt about Washington's responsiveness to our wills arises from our inability to alter the Administration's Vietnam policy which seems locked on course. The Administration promulgates a full-scale war without asking Congress to declare it. It escalates this war in the face of crescendoing editorial, church, and university opposition. Citizens bombard the Administration with telegrams and paid newspaper advertisements. They hold the largest peace demonstrations since the Civil War. They engage in civil disobedience, burning their draft cards, burning flags, refusing to pay portions of their income taxes. They mount Vietnam Summers and teach-ins. And who, in Washington, listens?

Let me be precise: I am not saying the American people *have* lost control. I say only that I am not sure they have not or will not. No one is charging a conspiracy to take power away from us.

* Gross National Product.

** Cf. Ronald Segal, *The Race War* (New York: The Viking Press, 1967).

† For details see, e.g., Noam Chomsky's "The Responsibility of the Intellectuals" in *The New York Review of Books*, Feb. 23, 1967.

But many have begun to wonder whether with the mammoth complexity of issues and bureaucracy our democratic structures have grown too arthritic, too flat-footed to counter the political interests of an administration, the power interests of the military, and the economic interests of industry—a coalition initially intimidated by Eisenhower and currently monitored by Galbraith. It is easy to give an *abstract* answer to what the situation requires: it requires that we rejuvenate our democracy, dilating its channels of communication and toning up its responsiveness to the people's will lest the drift towards power concentration proceed unchecked. To pour concrete content into this abstract formula is not easy, but is worth every effort. The United States isn't a simple place to live today, but it is an interesting and important place. For here, it seems, is where history is going to discover:

- whether man can transcend his racial divisions.
- whether he can soften his national divisions.
- whether he can live in cities the size of ours.
- whether he can redress the world's imbalance of wealth and power.

A CULTURAL PROBLEM

Politics so dominates the news that it often misleads us into thinking it dominates life. It doesn't. Private life, which the Russian essayist Rosanov characterized as "picking your nose and looking at the sunset" but which includes interpersonal satisfactions as much as the physical and aesthetic ones Rosanov cites—private life counts for more in the happiness of most men than do ideologies and affairs of state. "Can I honestly enough confess," wrote Mon-

taigne, "with how very trifling a sacrifice of my tranquility and peace of mind I have lived almost half my life while my country was in ruins." Dr. Johnson concurs: "How small of all that human hearts endure, the parts which kings or laws can cause or cure. . . . Public affairs vex no man and the news of a lost battle never causes any man to eat his dinner the worse." Carl Jung's autobiography doesn't even mention World War II.

I cite these facts and views to remind us that even in a nuclear world not all our important problems are political ones. Having opened with a social problem and centered in one that is political, I conclude with one that is cultural.

Let me move into it as follows:

Life begins as a bundle of needs. I really know of no more precise definition of an infant than this: a bundle of needs. Our job in life is to see that these needs get satisfied. The mischief is that we don't know what our needs are; if we did half the battle would be won. We don't know in any precise sense what our needs are, but we do know that they are of two general kinds. On the one hand are practical or physical needs; on the other our passionate or emotional needs. We need to eat and we need to feel; we need to eat well and to feel well.

Being human, we have in addition to these needs, minds. These minds can help us to fulfill both our practical and our passionate needs; they can help us to eat better and to feel better. The mind working to help fulfill our practical needs is technology. When early man figured out how to build his first bear trap to improve his food supply he started a line of endeavor that has continued right down to combines, spinning machines and antibiotics. Meanwhile the mind

working to fulfill our passion needs produces art, philosophy and religion. The arts—I use this word broadly to include not only poetry, painting, music, theater, and the dance but also theology and aspects of philosophy—enable us to fulfill our passion needs by providing forms through which our feelings achieve formed resolution. In becoming thus resolved, our feelings get simultaneously clarified, deepened, and expressed.

The man in the street can no more be his own artist, seer and prophet than he can be his own scientist; he needs help in both directions. The creations of our Isaiahs, Michaelangelos, Dantes, and Beethovens, together with those of innumerable unnamed myth-makers and songsters, coalesce over the centuries into cultures. But this brings us to the cultural problem of our time. Social change has proceeded at such a pace—some estimate that life has changed more in this century than in all the centuries since civilization was founded up to this one—that our culture has fallen behind. Its forms don't connect with our feelings as they once did. The power has gone out of them. This leaves us with a mass of inchoate feelings churning around inside us with nowhere to go; no channel through which to find expression in formed resolution. The consequence is frustration, like sensing an ocean of love latent within oneself with no one around to focus it on and express it to. So "Burn, baby, burn," in Watts, California, and "Rage, rage against the dying of the light."

The cultural need of our time is for geniuses capable of creating cultural forms that speak convincingly to today's feelings. We don't recognize this need. The necessity of using our minds to meet our practical needs, the necessity of technology we understand; but either we don't recognize that our passion needs are as important as our physical needs or we don't see that the mind can help satisfy them. So we appropriate upwards of \$2 billions for the National Science Foundation and National Institutes of Health and \$11.2 million for the National Endowment for the Arts and Humanities—a way of saying we think our practical needs are 200 times as important, or as amenable to treatment, as our passion needs.

When Renaissance Florence *wanted* artists it got them.

Aldous Huxley used to characterize man as a multiple amphibian: he lives in, and oscillates between, a number of environments. The three I have scanned are the political, the social, and the cultural. Respecting each, our time calls for choices. In this striking moment in history, this nuclear world in which we live, we need to revitalize democracy in the political sphere, rebuild community in the social sphere, and call forth from our midst (by recognizing our need for them) artists who can update our culture by creating new and compelling aesthetic forms.

The three notes should be struck as a chord.

RESEARCH

STRESS IN HIGHER EDUCATION AND STUDENT USE OF UNIVERSITY PSYCHIATRISTS

Benson R. Snyder, M.D. and Merton J. Kahne, M.D.

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This paper reports demographic and personality characteristics of student users and nonusers of a college psychiatric service. It describes, as well, techniques used to clarify the importance of the social structure of the college environment in stressing, shaping, or retarding the intellectual and emotional development of its students.

This paper reports one part of a larger study on the adaptation of students to the process of higher education.⁵⁻⁷ The 893 students in the MIT class of 1965 were followed through their four undergraduate years, and approximately 100 demographic and psychological variables were collected about each student. Specific paths, such as course changes and changes in living group, were determined for each student and for various groups of students. The movement of the class through the eight terms was considered as a stochastic

process (first order Markov chain), and the resulting conditional probabilities of specific moves were calculated. The conditional probability of the use of other formal helping resources by students on the several paths were also worked out.

Two hundred and nine students were seen in the psychiatric service at least once during the four years. This represents 23.4% of the entering class, and when corrected for attrition it represents 30% of the students on the campus in their senior year. This paper considers certain similarities and differ-

This paper is a revised version of one read at the 1968 annual meeting of the American Psychiatric Association, Boston, Massachusetts.

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ences between students who use a college psychiatric service—users—and those who do not—nonusers. In interpreting the data, the nature of the educational environment and its meaning to students is given primary consideration.

GENERAL BACKGROUND

For the past seven years we have been evolving a broadly based social psychological inquiry into many different aspects of life at MIT. The research has three primary purposes: First, we hope to develop a detailed understanding of the process of educating scientists, engineers, and scientifically informed liberal arts students. Second, we also hope to extend our general understanding of personality development in late adolescence. Third, we aim toward an integration of the concepts generated by the research into a coherent description of the educational scene as a useful basis for institutional planning. Our methods have ranged from studies of individual students to surveys of groups; from examination of intellectual development to analysis of institutional structure and change. In short, the emotional and intellectual lives of the students and faculty are being examined within the educational environment in which they work and live.

The student who is unable to function in an academic environment because of depression, anger, or alienation immediately poses a number of questions. When is he to be thought of as sick? If he is considered ill, the physician's diagnosis of the student's condition usually carries with it an assumption about its cause and, beyond that, determines his prescription for therapy. Should the physician see the student's illness as the result of some external agent—like an

infectious disease model—he will almost certainly evaluate the influence of the environment in a very different way than if he attributes the student's illness to a moral weakness. The relationship of presenting symptoms to specific pressures or events on campus has been, for us, the initial question—rather than asking whether this is illness. Such a study of the student's experience tells us as much about the environment as about the student. This strategy has put us in a position to begin to evaluate the relative importance of a wider range of factors than otherwise might have been considered.

On the basis of our larger study we found that the educational environment extended the capacity of some students to adapt to a range of stimuli while it appeared to lock others into reliance upon one narrow skill.⁸ In the process of achieving mastery over a given educational task, students' cognitive and adaptive styles at times became so fixed that their ability to cope with altered circumstances appeared to be limited. Severe restriction in adaptive potential may then be the price that is paid for a parochial and temporary success in education. For example, the student may maintain his high grade-point average by closing off many activities and feelings which he considers extraneous to his immediate educational task, that is, passing the next examination. This may be a kind of ecological trap for the student in today's education, and indeed for institutions of higher education.⁹

We have begun to ask ourselves: Does the educational institution ask the student to limit seriously his adaptive potential in order to give him an A? Does that which the institution asks of its students run counter to the develop-

mental tasks of adolescence? Can the student do well in school and still develop, for example, the ability to take informed intellectual risks? Is the instrumentally motivated student sick? And we have learned to appreciate the possibility that his narrow mode of adaptation—the blinders that he has put on—may well protect him from uncertainty, alienation, or a sense of helplessness, and thus, from the signs and symptoms of more active conflict which is more easily recognized as sickness.

It is necessary for the psychiatrist to be aware of such complex influences on the individual. These influences provide a research challenge, since not nearly enough is known as yet about the social-psychological effects of educational institutions upon its members. As clinicians we know that knowledge of the educational community is crucial to assessing a student's capacity to perceive and to develop realistic strategies for coping with his particular environment.

THE SETTING AND THE STRATEGY EMPLOYED IN THE STUDY

The psychiatric service of the medical department of MIT is not limited to undergraduate or graduate students. It is available, at least for consultation, to all members of the entire MIT community. For the past five years, approximately 900 individuals each year, or about 5% of the 18,000 in the MIT community, have sought our services. In any one year, slightly more than two-

thirds of this number were seen for the first time. During this period, approximately 10% of the undergraduates consulted the psychiatric service during each year, 5% of the graduate students, 5% of the faculty, staff, and employees, and approximately 1% of their dependents. Our experience is that the students' trust in the service is enhanced by their knowledge that all members of the community make use of this service. They do not see it, as is frequently the case, as a dispensary or as a special service limited to students.³

Comparisons of the students from the class of 1965 who consulted the psychiatric service with those who did not were based on frequency distributions of selected demographic and psychological variables. Demographic variables included data about socioeconomic status, family status, secondary school, and academic performance at MIT—including the academic path that the student followed. Changes in the student's living group while at MIT were also known. There were two major bases for our psychological inferences. One came from the Omnibus Personality Inventory that was developed by McConnell and Heist² at the Center for Study of Higher Education, Berkeley. This inventory, an instrument of 575 items, was given on a voluntary basis to 91% of the freshmen who entered MIT in September of 1961. Seven hundred and twelve (81%)* of these students completed enough items to be in-

* The test was administered during the first week of the academic year. We have gone to considerable pains to evaluate the representativeness of the results of this sample both for the class as a whole and for user and nonuser subgroups. With the singular exception of the fact that by the second term, the number of withdrawn or disqualified students among those who had not taken the test as freshmen was significantly higher than among those who did (these differences disappear by the fourth term), we could discern no significant differences between those who did and those who did not take the test. For an extensive discussion of this and other aspects of our experience with the test see Reference 1.

cluded in the analysis. The other basis for our inferences was a random stratified sample of 54 students who were interviewed four times during their four years at MIT. These were 1½-hour semistructured interviews, the majority conducted by the senior author.

RESULTS

For purposes of discussion, we have summarized our findings under three headings: first, the demographic differences between the users and the nonusers; second, the findings on the Omnibus Personality Inventory; and third, a discussion of the inferences drawn from the patterns of use of helping resources as correlated with grade level, with living groups, and with academic paths that were followed.

We found no statistically significant difference in the mean Scholastic Aptitude Test scores between the user group and the nonuser group.

Like Scheff⁴ we found that, as a group, students who consult the psychiatric service during their four years on campus are more likely to come from the higher socioeconomic levels. Thirty-five percent of the fathers of users had attained professional status while only 31% of the fathers of nonusers had done so ($p < .002$). The fathers of the users had more formal education (60% had graduated from college) than nonusers. Only 52% of the latter group completed college ($p < .001$). The same was true when mother's education was examined: 36% of mothers of nonusers and 39% of mothers of users had graduated from college ($p < .002$).

Users most often came from two-

children families in which there was a brother, while nonusers were more likely to have several siblings of both sexes. This has led us to speculate that male students who do not have sisters may have had intensely competitive experiences with their brothers that in later adolescence left them more vulnerable to complicated transference phenomena under the pressures of MIT's predominantly male environment.

Users had a higher percentage of mothers known to have died prior to a student's admission to MIT (3.3%) than did nonusers (1.6%). This difference suggests a trend which did not, however, achieve statistical significance. Nor was the death of the father prior to the student's admission significantly associated with his becoming a user—5.3% fathers of users were known to be dead as against 4.5% fathers of nonusers. On the other hand, a broken home before the student's admissions was found to be associated with an increase in the probability of becoming a user. Specifically, the percentage of student users whose parents had divorced or separated prior to the student's admission to MIT was 6%. This was the case among only 3% of the parents of nonusers ($p < .01$).

Among the 712 students who took the Omnibus Personality Inventory, users differed from nonusers in a number of interesting respects. Five of the scales* showed significantly higher scores for the users than for the nonusers (see TABLE 1— $p < 0.01$). These scales were: Aestheticism, Complexity, Autonomy, Religious Liberalism, and Impulse Expression. Thinking Intro-

* For a listing of items comprising each scale, see Reference 2. For a discussion of the sense in which these scales have been understood by our group, see Reference 1, pp. 1-15.

Table 1

MEAN FRESHMAN OPI SCORES FOR STUDENTS WHO VISITED THE PSYCHIATRIC SERVICE AND FOR STUDENTS WHO DID NOT VISIT THE SERVICE, CLASS OF 1965

SCALE	USERS (n=163)		NONUSERS (n=558)		F
	Mean	S.D.	Mean	S.D.	
Thinking Introversion (TI)	56.1	9.33	54.2	9.00	5.411 ^a
Theoretical Orientation (TO)	60.8	8.53	59.7	8.28	2.023
Aestheticism (ES)	50.9	9.10	47.9	9.24	13.187 ^b
Complexity (CO)	58.6	9.71	55.4	10.28	12.109 ^b
Autonomy (AU)	55.6	8.47	52.9	8.97	11.915 ^b
Religious Liberalism (RL)	54.0	10.70	51.2	10.92	7.923 ^b
Social Introversion (SI)	51.9	11.67	53.2	10.59	1.665
Impulse Expression (IE)	54.8	10.69	51.8	10.35	10.203 ^b
Schizoid Functioning (SF)	51.8	10.84	49.8	10.32	4.243 ^a
Lack of Anxiety (LA)	48.7	11.11	51.4	10.51	8.664 ^b

^a Significant at the .05 level.

^b Significant at the .01 level.

version and Schizoid Functioning were only slightly higher for the users than the nonusers ($p < 0.05$).

The scores on the Lack of Anxiety scale were lower for the users than for the nonusers, ($p < 0.01$). When the score on this scale was low, we inferred a greater conscious acknowledgement of anxiety. Thus, those students who acknowledge their anxiety at the time of admission to MIT were more likely to consult the psychiatric service sometime during their four years than the students who did not acknowledge anxiety (as inferred from a high LA score). As one might expect, students who became psychiatric service users during their freshman year had a lower mean Lack of Anxiety score at the time of admission than did the population of students who did not become users.

The following study was more informative than comparisons of mean scores for large groups: Two extreme populations were chosen using scores on the Lack of Anxiety scale that were more than one-half sigma above or below the MIT mean. There were a larger number

of users in the more anxious population. No differences between users and nonusers were found when similar procedures were carried out using Theoretical Orientation or Social Introversion scales.

Our OPI data showed no apparent differences between the users and those who did not become users when we evaluated it in terms of inferred neurotic character type. In other words, we could find no convincing evidence from the Omnibus Personality Inventory that a neurotic character structure was an important determinant of a student becoming a user. The absence of important differences between the groups of users and nonusers on Social Introversion and Schizoid Functioning scales is consistent with this inference. Examination of the protocols of the interview sample also dramatically support our assertion.

Users appeared to share values, attitudes, and perhaps a worldview which differed from nonusers even as early as entrance to college. To the extent that this was so, the students who became users may have perceived their environ-

ment and the events of their first and subsequent years through a different frame from that of their nonuser classmates. The Thinking Introversion, Aestheticism, and Religious Liberalism scales were consistent with this particular mode of perception, while Impulse Expression, Autonomy, Complexity, and Lack of Anxiety scales may be related to the individual's reaction to new stimuli, to dissonance, and to risk-taking. The OPI findings, while perhaps differentiating the two groups, are consistent with our inference that most users are relatively normal students who are undergoing stress. (The similarities between the two groups may be seen more clearly in FIGURE 1, which recapitulates in bar graph form the data in TABLE 1.)

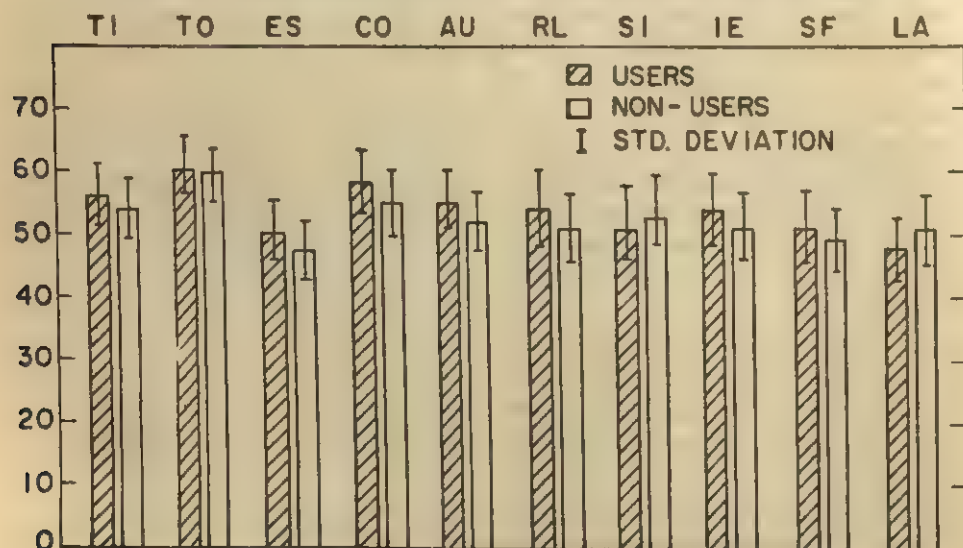
Though cautious about drawing inferences about large groups from the results of personality evaluation via inventory tests, certain generalizations are

in order. Freshmen, as users of psychiatric facilities, were more conscious of their anxieties than were nonusers, and it is important to note that they had qualities that MIT values highly: an appreciation of a broad range of intellectual interests, tolerance for ambiguity, autonomy, and a relative lack of stereotypical responses. Indeed, if the performance on these various scales adequately mirrors the way in which they live, it may well be that their consciousness of anxiety is related to their receptivity to stimuli, to dissonance, and to risk-taking.

Turning more directly to a consideration of the environment, we have forceful evidence that the nature, intensity, and location of educational and other stresses strongly affect patterns of the use of psychiatrists by students. We have reported elsewhere some of our evidence that the stresses also affect the student's

Figure 1

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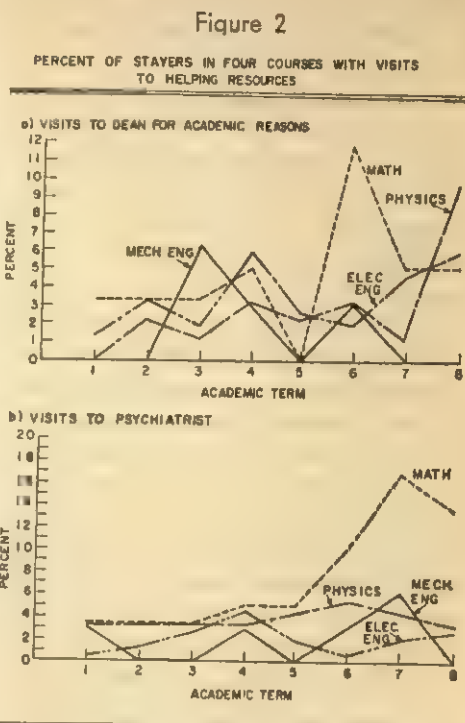


movement along his path in college and his academic survival in a given course.^{5,7} We have begun to identify some of the strains which students develop in response to the academic or social stress within their environment that then lead some to seek consultations and help. Two kinds of data illustrate the way we have located the time and place of stress as a factor that influences the need for psychiatric consultations.

First, we compared the term-by-term percentage of use of the psychiatric service and other helping resources available to students of the class of '65 between September 1961 and June of 1965. Separate rates of use were calculated among students majoring in each of 15 different academic disciplines and also among students living in each of 10 identifiable living groups. Here we were looking at essentially epidemiological data and asking ourselves whether the findings could tell us something about the intensity and time of occurrence of stress along a student's chosen path. The use patterns over time were then charted. FIGURE 2 illustrates patterns of consultation among students who selected a major course of study and stayed with it throughout their undergraduate careers.

These examples reveal graphically that the courses have different rates of student use of psychiatric and other helping facilities and that the peak in use of such consultation occurs in different semesters in a number of courses.

The potential usefulness of this approach is suggested by the following additional preliminary findings. The peak period of use of the psychiatric service by students in one of the larger science courses occurred during the stu-



dents first term as majors in the course. For another large science department, the period of greatest use came in the first term of their senior year. We interpret differences such as these as consistent with an hypothesis that these two departments presented their students with significantly different stresses at different points in time.

One living group made consistent use of the medical outpatient department over the four-year period but made relatively little use of the psychiatric service. Another living group of approximately the same size and with similar student characteristics used the psychiatric service as its major, formal, helping resource. This observation, strengthened by our interview data and knowledge of the types of problems which the students

in the first group were bringing to the medical department, suggested to us that the definition of a problem as relevant for psychiatric consultation was related to shared notions in the living group about the "causes" of such experiences as anxiety or depression and about the appropriateness of discussion and introspection for the solution of such problems.

In a related study we found that about 75% of the 40 students living on one floor in a dormitory came into the psychiatric service in one semester. The student rate of use for the rest of the dormitory did not show any appreciable rise during this same period. As we studied the events in detail, retrospectively, it appeared most likely that in this part of the dormitory the usual informal social supports upon which students ordinarily rely had broken down. We found that a sense of helplessness and anomie had developed among the students which eventually resulted in their increased use of the service.

Second, approaching the same issue using another research strategy, James Taylor made an attempt, under our auspices, to capture the dynamic interplay between conditions of residence, academic performance, personality type, and the use of various "helping resources."⁸ For our purposes here, we will focus on one particular resource—the psychiatric service.

Data from the class under study were organized as follows: Three students' residence houses were selected for study on the basis of the percentages of students who moved out of and moved into the houses.

Students who remained in one house throughout eight terms were compared with students who made their first change

of residence out of that house and those who made their first residence change into the house. Movers-out were thus the same as movers-in when they were grouped according to different referents. Academic performance as measured by term ratings, personality changes as measured by test-retest scores on the Omnibus Personality Inventory, and the use of the helping resources as measured by the frequency of visits to the medical department, the infirmary, the dean of student affairs, and the psychiatric service were evaluated. Analytic techniques consisted of the t-test, analysis of variance, and Kendall's coefficient of concordance. Where residence changes occurred, the time of change was used as the principal referent for the analysis of the flow of events.

The main conclusions in the study were:

1. In general—that is, for all houses—movers-out show significantly lower academic performance and higher use of counseling resources than those who remained or movers-in. Grades tended to drop before the residence change and to improve afterward.
2. In the house with the greatest turnover, movers-in had lower grades than did movers-out. Of all three residence groups, occupants of that house used all of the helping resources least. Yet those who stayed or moved in contributed to the highest mean levels of Anxiety, Impulse Expression, Schizoid Functioning, and Social Introversion of all three student groups.
3. The house with the middle range of turnover lost students with very low grades and attracted students who were performing better academically. Occupants of the house tended on personality assessment to be highly socially oriented

and, interestingly enough, tended to use all helping resources more than those in either of the other houses. On the Omnibus Personality Inventory, students in that house displayed the lowest mean Social Introversion score and the highest Aestheticism scores. It was the only house in which the mean anxiety scores dropped between freshman and senior years and the students there showed the largest drop of all houses on the mean Schizoid Functioning scale.

4. The house with the least turnover tended to attract students with very high grades and to lose students with lower grades. Its residents showed few symptoms and exhibited high academic performance. Whereas on the Omnibus Personality Inventory measurement its occupants initially showed the lowest level of Anxiety, Impulse Expression, and Schizoid Functioning, it tended to attract students who were higher on the Anxiety scale and Schizoid Functioning than those who originally lived there.

In our view the academic performance of these students is best seen as a consequence of, rather than as a cause of, change in living groups. To the extent that students experienced stress in their living arrangements, this appeared to be reflected in the falling grades. And the patterns which emerged suggest that the helping resources, where they are used, play an instrumental role in improved academic performance and probably contribute to more appropriate residence selection.

When students were divided into those who remained, those who moved, and those who withdrew from school entirely, important differences in the use of the psychiatric service also emerged. For example, in several courses psychiatric consultation appeared to be cor-

related with a drop in grades, while in other courses such a correlation did not obtain. Students who consulted the psychiatric service prior to a move from one course to another were far more likely to remain at MIT after the course change than were those who consulted the psychiatric service in the term following the course move. Students in the latter group were likely to withdraw in subsequent terms.

When we separated users into two groups of those who had one visit and those who had more than one visit, it became evident that the probability of remaining at MIT and being a user was considerably higher in the fifth through the eighth terms if there had been more than one visit. For students who stayed at the Institute for four years, the probability of consulting the psychiatric service was greatest during their seventh term.

We next compared the students' use of the psychiatric service with their concomitant use of other formal helping resources. The probability of being a user and having a medical visit was greater in all eight terms than being a user and not having a medical visit. In general, in the seventh semester the probability of being a user and having a medical visit was two times the probability of using only the psychiatric service.

This same pattern was found when we examined infirmary visits. Again, there was a marked increase in the seventh semester. Finally, the probability of a student using both the dean's office and the psychiatric service was 6 to 10 times higher than using the service without seeing the dean. And once more, we find the highest contingent probability of being a user with a contact with a dean during the seventh semester.

Organization of our information in this way has helped us locate stress points in the educational process. These data, for example, suggest that it would be wise to undertake a more careful investigation of just what is occurring in the lives of students at MIT during the seventh semester which generated this increased use pattern. Currently we can say that these findings appear to point to an adaptive crisis in the students rather than to the sudden emergence of neurosis. Many users with serious neurotic difficulties—especially when the neuroses limited the students ability to learn—have left the Institute by the end of their sophomore year. A new group appeared to make use of the psychiatric service in the last two years of their college careers. Information such as this suggests to us that these students were responding more to dissonance and stress within their environment rather than primarily to intrapsychic conflict.

Lastly, by examining the use of the psychiatric service by both the class of 1963 and the class of 1965, several broad groups of students were identified: (1) Students who make one visit. These students had a higher proportion of administrative referrals from such groups as the dean's office, the committee on academic performance, and occasionally the discipline committee or medical department. (2) Those students who made two or more visits, largely self-referred, and who represented about 65% of the case load. (3) Students who used the psychiatric service on an emergency basis, typically with severe depression, feelings of panic, suicidal feelings, a vague sense of terror, and those with incipient psychosis—such students made up approximately 10% of the total number of students who consulted the psy-

chiatric service. (4) Those students, largely but not exclusively from the third group, who were hospitalized. This group made up 1% of the total. (5) Those students who were initially seen in the psychiatric service and were then referred for long-term psychotherapy. They constituted approximately 10% of the total number of students who had consultations.

In order to cast the issues raised by the comparison of the user/nonuser groups in human terms, here are brief histories of two students:

The first student was referred to the psychiatric service by his faculty advisor. A junior in one of the major fields of MIT, he was doing mediocre work. A central academic task in his major subject required, among other things, that he pass frequent one-hour quizzes which were designed to test his ability to manipulate specific formulae. His advisor suggested that he change his major in view of his poor grades. The student was unhappy about this suggestion. After an extended discussion, his advisor suggested that the student might benefit from consultation with one of the psychiatrists. The student, though skeptical, came in.

In consultation it developed that he had spent a great deal of time proving all of the formulae to himself and working out new, different ways of solving problems for his own satisfaction. He had seen it as "a point of honor" not to study for exams. His mastery of the specific academic tasks in his subject had been perceived, in a psychological sense, as the equivalent to surrendering his personal liberty. He had managed to provoke most of his professors by his constant, though silent, challenge. This attitude had been present throughout his adolescence. Further, he had tumultuous battles on occasion with almost all of the authority figures in his past, particularly with his father.

As the psychiatrist listened to the history unfold, he was struck with the possibility that this young man's questioning as much as he did, his acceptance of so little as given, could have led him to achieve an unusually broad and deep understanding of his specialty. It appeared

at least possible that beyond his rebellion, he might have been preparing himself for a useful, productive, possibly creative, scientific career in later life. In order to clarify this issue, the student was asked to return to his advisor and this time discuss his knowledge of the field. The advisor confirmed that the student had indeed a level of sophistication usually expected of first- or second-year graduate students. The therapeutic task was then structured to help the student see those aspects of his behavior which were self-defeating and face and deal with the irrational element in his rebellion without turning him into a conforming carbon copy of his peers.

Let us now contrast the student who had used the psychiatric service with a student who we came to know through his participation in the Student Adaptation Study but who never became a user of the psychiatric service.

This student, a sophomore, had done well in high school without the expenditure of effort. During his freshman year at MIT he had his first experience of failing a quiz—of not understanding immediately and easily all that went on in his classes. One of the implicit tasks for freshmen is to master the technique of selective negligence, to organize time and set priorities on what will be done or not done. This student, overwhelmed by demands on his time, reacted by gradual withdrawal from what he saw as “the scene of battle.”

From his account of his childhood given in the sophomore interview, it appeared that in his early years he had had a conviction that he could not influence his parents' relationship to him. His language suggested that he saw his father as a superman who could only be influenced by magic. His father, and indeed the whole family's ethos, did not appear to allow for acknowledgement of failure or personal distress. For example, during his adolescence the family had been faced with a severe economic crisis which his father first denied and then apparently explained to his son in magical terms. Whether the student's memory on this point is accurate is open to question. The important issue is that this was

his perception of the event. Faced with an academic crisis in late adolescence, the student still was using, it appeared, magical explanations to explain his inability to function.

Weight-lifting and other rough physical pursuits were replaced in this young man's adolescence by his consuming preoccupation with developing a potent and unbeatable intellect. He spoke of wanting a “strong mind” the way that other young men want large biceps. Throughout his interview, there was considerable evidence to support an inference that the student identified with the strong aggressor and needed to see himself as a superhero. Behind these defenses lay considerable anxiety about his weakness—his terror of defeat. He gave several instances of sudden, unexpected impotence which broke through his counterphobic defenses. In his freshman year, for example, the student had gone into an examination and recalled observing the fright on the faces of his classmates. He was surprised when half an hour later he froze, his memory failed, and he flunked the exam. Science and engineering seemed to serve as this student's touchstone to his own private brand of supermasculinity. His encounter with MIT took on many of the qualities of a magical initiation rite. As his academic difficulties mounted, he explained his increasing failure as due to memory loss, and reacted by putting his books under his pillow. He appeared to be trying to use his scientific education magically to strengthen his mind. During this period, he actually appeared threatened by the obvious anti-magic bias in the content of his subjects.

This young man had considerable latent ability as inferred from his SAT scores. His cognitive processes, however, were caught up in a pervasive neurosis. Thinking, learning, grade-getting, had all assumed a special defensive significance for him which crippled his ability to see the relevant academic tasks. The more he felt threatened, the more he attempted to manipulate his environment by a magical propitiation. Such desperate efforts failed to maintain his self-esteem. The first year's educational task of reducing the environment to knowable parameters—of learning to selectively neglect—became a major blow to this defensive stance. He withdrew from MIT in the

fourth semester on the verge of failure, having neither felt the need for, nor to our knowledge having been advised to consult, the psychiatric service. At the end of the research interview, we urged this student to explore his academic problems further with a member of the staff, but he did not come in.

DISCUSSION

We have found that distinctive use patterns significantly differentiate one student group from another. Socioeconomic status of the parents, as reflected in father's occupation and the education of both, is a factor which influences who will use the psychiatric service. Other prior events in his biography, such as parental divorce, also influences the student's decision.

Beyond this, the psychiatric service appears to be perceived and thus can be used as something more than simply a facility for the treatment of mental illness. Nor does the psychiatric service function as an administrative device for "cooling out" failing students or other institutional rejects. Rather, it appears to function more like a clearinghouse where individuals with vaguely defined, often contradictory social perceptions can find an informed neutral arena where time is made available for examination and clarification of the issues.

Students develop a variety of strategies to deal with the almost inevitable dissonance between their past, their present, and their hoped for future. We found that certain strategies, certain solutions used by students, had a much higher survival value in one academic field than in another. For example, students must learn to selectively neglect certain activities and to assign strict priorities to the

subjects they study if they are to maximize their academic standing. The institution as much as the student sets the odds on the strategies which help him to survive in the immediate present and the coping patterns that will lead to academic success. Those strategies which help him to survive in the immediate present do not automatically serve the student well in mastering his field or in developing his intellect. It is precisely this that challenges us to consider the consequences of our curriculum for the development of excited, imaginative, and concerned students. It is this consideration which has taken us out of the consulting room and into the classroom and living groups as participant-observers.

One of the dangers of a precipitous psychiatric diagnosis is that it may set the student apart and allow the institution as well as the psychiatrist to focus too exclusively on those factors within the student that are associated with his distress. An investigation of the encounter between the student and his environment lessens this risk. From the study of such encounters the institution can begin to build up a sophisticated, although complex, picture of what it takes for students to survive and what is involved in failure.

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THE DEVELOPMENT OF MATERNAL RESPONSIVENESS IN THE RAT

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Maternal responsiveness in the rat develops gradually during pregnancy and parturition, and in the postpartum period of maternal care. Virgins can be shown to have a basic level of maternal responsiveness, which is raised during pregnancy and again at parturition. After parturition the young maintain the mother's maternal responsiveness, but there are indications that as they grow older they cause a decline in her responsiveness. Maternal responsiveness is shown to be based upon substance(s) carried in the blood of the postparturient mother. Transferring blood plasma from a new mother to a virgin causes the latter to become maternal towards young within 48 hours, where normally it requires two to three times this period of exposure to young.

In recent years there has been an enormous increase in the study of maternal behavior among a wide variety of animals. To the studies of this behavior among lower mammals (rodents, lagomorphs) and more advanced mammals (carnivores, ungulates, etc.) have been

added very extensive field and laboratory studies of maternal behavior among the subhuman primates and among humans.^{9, 10, 18, 20, 28} There is little doubt that the central place of maternal behavior in social behavior and organization and in the development of the young

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among mammals has attracted the interest of psychologists, ethologists, psychiatrists, and anthropologists.³⁰ These studies have thus far been largely descriptive, focusing on the mother-young relationships as introductory to the analysis of maternal behavior as part of the reproductive cycle and the life of the mother herself.

The study of maternal behavior in the rat and other small mammals (e.g., mouse, hamster, rabbit, dog, and cat) has gone somewhat further in the analysis of both the psychophysiological basis of maternal responsiveness and the stimuli from the young which govern the mother's behavior. Theoretical and experimental problems met in the course of further analysis of maternal behavior in these species are likely to be met also when studies on higher mammals, particularly the primates, are undertaken. For this reason it is appropriate to address this article to a group that otherwise would not be particularly interested in the study of maternal behavior in the rat.

Our research on the maternal behavior in the rat has ranged over the entire period of the reproductive cycle from conception (and even earlier) to weaning of the young. From this perspective, covering nearly two months, for the first 22 days of which the female is pregnant and the remaining 28 days she takes care of her young, we have developed certain conceptions about the *onset of maternal behavior* at parturition, its *maintenance* during the three to four weeks that follow, and its *decline* at the weaning of the young. In the following we shall present the evolution of these conceptions and the experimental evidence upon which they are based.

Our approach to maternal behavior in

the rat has been a developmental analysis rather than an analysis in terms of the concepts innate and learned. A similar approach to reproduction and parental care among several species of birds by Lehrman^{18, 19} and Hinde¹¹ and their co-workers has been highly successful in revealing the developmental processes underlying successive phases of the reproductive cycle. These processes involve hormone secretions and their motivational as well as other effects on reproductive behavior, the appearance of characteristic behavior patterns at various phases of the cycle in relation to the mate, nest, eggs, and young, and the effects of stimuli from these sources altering and advancing the reproductive behavior of the female.

Viewed developmentally, maternal behavior in the rat appears about midway between conception and weaning of the young; the mother passes through the three main phases we have indicated above. There is no reason to believe that the psychophysiological basis of maternal behavior and factors which influence its development are the same during the different phases. Each phase requires analysis in terms which are appropriate to events of that phase, and the separate phases need to be related to one another in a developmental sequence. The aim of this article is to attempt a preliminary analysis and integration of this sort for the rat.

Mammals as a whole have achieved an organization of maternal behavior which is both characteristic of the class and markedly different and more advanced than exists in any other class of animal.⁴² To the extent that maternal behavior in the rat shares in features of maternal behavior common to all mammals, an analysis is relevant for the study

of human maternal behavior. But maternal behavior has also evolved among the mammals and to that extent analysis of maternal behavior in the rat cannot be said to provide the entire basis for understanding human maternal behavior.

MATERNAL BEHAVIOR AFTER PARTURITION

Maternal Behavior Cycle. Maternal behavior normally appears during a specified period of the reproductive cycle, the 3- to 4-week period that follows parturition. Its appearance at this time, in association with lactation, known to be under hormonal control, suggests that it too is based upon a special hormonal condition postpartum. Maternal behavior in the rat can be divided into the three phases shown in FIGURE 1 (upper graph). The earliest phase extends from the 1st to the 3rd postpartum day and is the *initiation* phase; nursing, retrieving, licking, and nestbuilding the principal components of maternal behavior are initiated and practiced with vigor and intensity during this phase. During this and the next phase (*maintenance*—from the 4th to the 13th or 14th day) the female initiates all feeding by approaching the young in the nest, licking them, and crouching over them. The 3rd phase of the maternal behavior cycle begins around the 15th or 16th day and extends until the 21st-28th day and is the phase during which maternal behavior *declines*. Maternal behavior declines in a regular order: nestbuilding declines first, followed by retrieving several days later, and then nursing, which may continue at a reduced level until the 28th day.

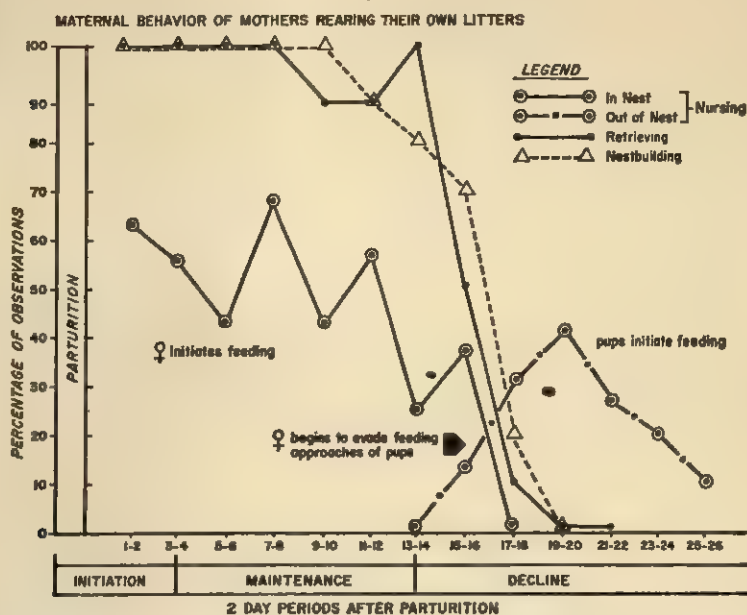
Behavioral Synchrony Between the Mother and Her Young. The phases of the female's maternal behavior cycle are

synchronized with stages in the physical and behavioral development of the young (FIGURE 1, lower graph). The initiation of maternal behavior during parturition coincides with the delivery of the young. The newborn and placenta possess attractive stimuli which elicit maternal behavior from the female. Newly born young with placentas presented to immediately postparturient females and even females in their 10th day postpartum are more attractive than cleaned pups without placentas and they survive until weaning in a significantly greater number of instances.⁸ Some feature of the newborn (e.g., movement) appears to inhibit the mother, after she has eaten the placenta, from eating the pup. Among mice,²⁷ *living* pups have an immediate effect upon the mother, stimulating her subsequent maternal behavior, while dead pups depress her subsequent maternal responsiveness to live pups. Newly born pups are also capable of reviving the maternal behavior of mothers in their 3rd week postpartum.^{25, 43} Stimulation from the young and placentas around parturition therefore play an important role in the initiation of maternal behavior.

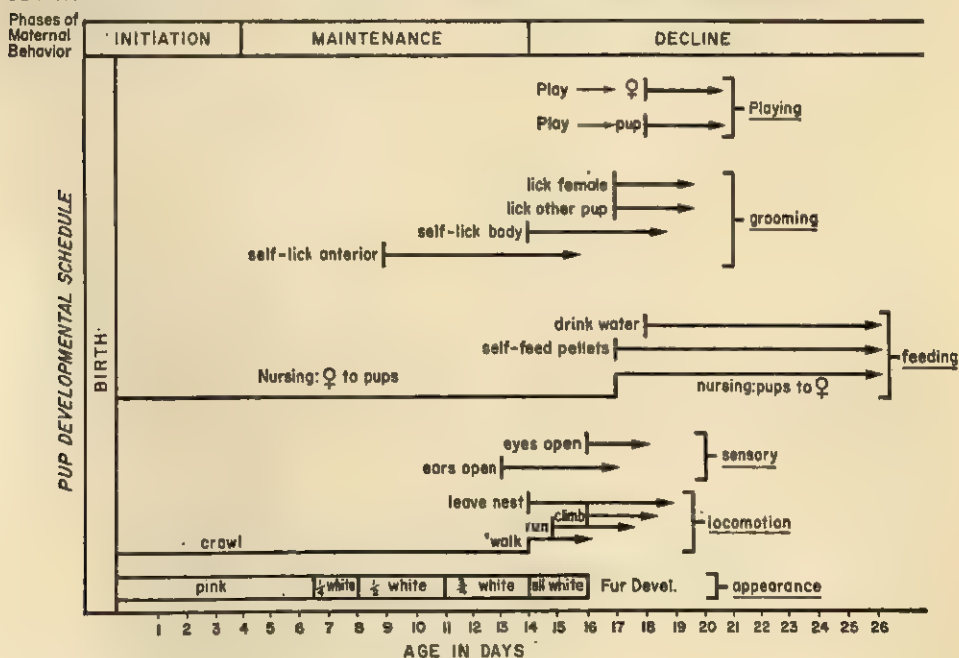
After delivery also, newborn are capable of stimulating the initiation of maternal behavior in mothers that have been prevented from contact with pups during parturition by Caesarean-section delivery.^{15, 24, 43}

The character of maternal behavior in the early phase is dependent upon the behavioral immaturity of the pups. Care of the young is initiated almost entirely by the mother and any interference with her maternal behavior, as for example by the effects of crowding in a rat colony,^{5, 6} results in the death of the young before the 3rd or 4th day.

Figure 1



BEHAVIORAL DEVELOPMENT OF THE YOUNG WITH REFERENCE TO THE PHASES OF MATERNAL BEHAVIOR



Summary of observations of maternal behavior (upper graph) and pup development (lower graph) of 5 litters of laboratory rats during the 4-week litter period. Maternal nestbuilding, retrieving, and nursing behavior are shown in relation to changes in the physical and behavioral characteristics of the pups.

During the *maintenance* phase the mother's behavior is stabilized and the pups gradually improve in crawling and in suckling. The beginning of the *decline* of maternal behavior in the third phase coincides with a period of rapid pup development. Fur gradually covers their entire body, and they show improvement in locomotion, progressing from walking to running and climbing. At around the 16th day they begin to feed and drink by themselves, thus initiating the process of weaning. These developments coincide with eye-opening and the beginning of hearing. Social interactions among the young and between the mother and the litter also become more varied, involving grooming and play activity.

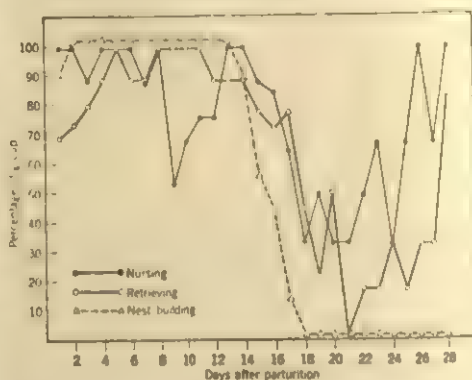
The decline of maternal behavior is therefore associated with the growth of independence of the young from the mother's care. Behavioral responses develop in the young which undoubtedly alter the mother's perception of them in such a way that she no longer responds to them as previously.

Maternal Responsiveness During the Cycle. It cannot be determined simply by observing the mother with her litter whether changes in her behavior during the cycle are based upon motivational changes (i.e., maternal responsiveness) or are simply changes reflecting new responses to the changing characteristics of her young. Maternal responsiveness might remain high throughout the cycle but with the disappearance of the stimuli which elicit maternal behavior this behavior might decline as the cycle progressed. To study this problem we used constant-age pups (5 to 10 days of age) to elicit maternal behavior. Mothers rearing their own litters were tested each day from parturition until the end of the 4th week; the results of this study are

shown in FIGURE 2. At about the same time that nursing, retrieving, and nest-building declined in the litter situation with pups that were in their 3rd-4th week they also declined in tests with the 5- to 10-day-old pups. Since these pups still provided adequate stimuli to elicit maternal behavior, although the mothers'

Figure 2

CYCLE OF MATERNAL RESPONSIVENESS



Cycle of maternal responsiveness in the female rat rearing her own young from the 1st to the 28th day after parturition. Graph shows the percentage of the group of mothers ($n=9$) that nursed and retrieved standard test young (5 to 10 days of age) and built nests each day.

own pups no longer did, the mothers' must have become unresponsive to these stimuli. We concluded that motivational changes are involved in the cycle of change in maternal behavior.

Maternal Responsiveness in Relation to the Pups. Having established that the maternal behavior cycle is based upon changes in female's maternal responsiveness, the question arose: What causes the changes in the female's maternal responsiveness during the cycle? In view of the behavioral synchrony that exists between mother and young, we have thus far studied the role of the young.

In our first study we removed the young permanently during parturition: six mothers were observed during parturition and the fetuses were removed immediately after they had been cleaned and the placentas had been eaten. Another group of mothers were allowed to give birth normally and to keep their young. At the end of the first week postpartum, both groups of mothers were tested for maternal behavior using standard test young (5 to 10 days old).

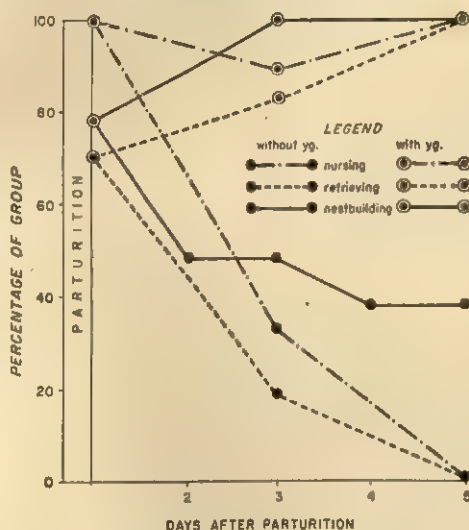
Almost all the mothers without young were completely unresponsive to the pups on the first test. Only 1 out of 6 of

these mothers nursed and retrieved the pups, while 4 out of 6 of the mothers with young nursed the pups and all retrieved them. Nestbuilding was also reduced in the mothers without young: only 50% built nests as against 100% of the mothers with young. In subsequent weeks the mothers with the young all showed the normal cycle of maternal behavior whereas the mothers without young remained unresponsive to the test pups. This study showed that maternal responsiveness was dependent upon stimulation received from the young; in the absence of this stimulation maternal responsiveness waned and was absent at the end of one week.

In order to discover the rate at which maternal responsiveness waned when stimulation from pups was absent, two additional groups of females were observed during parturition and the pups were again removed as soon as they had been cleaned and the placentas eaten. One group of mothers remained without young for 2 days and at the beginning of the 3rd day they were presented with 5 test pups and tested for their maternal responsiveness. Mothers of the second group were treated similarly except that they were presented with pups for the first time at the beginning of the 5th day. After 2 days without young only 20% to 35% of the mothers ($n=9$) nursed and retrieved the pups and only 50% of the group built nests (FIGURE 3). Nursing and retrieving could not be elicited in one-hour tests from any of the mothers that had been without young for 4 days and only 40% of them built nests.

After the tests were completed the pups were left with the mothers. With continuous exposure to pups it was possible to elicit maternal behavior from about 60% of both groups, but after a

Figure 3
POSTPARTURITION WANING
OF MATERNAL BEHAVIOR

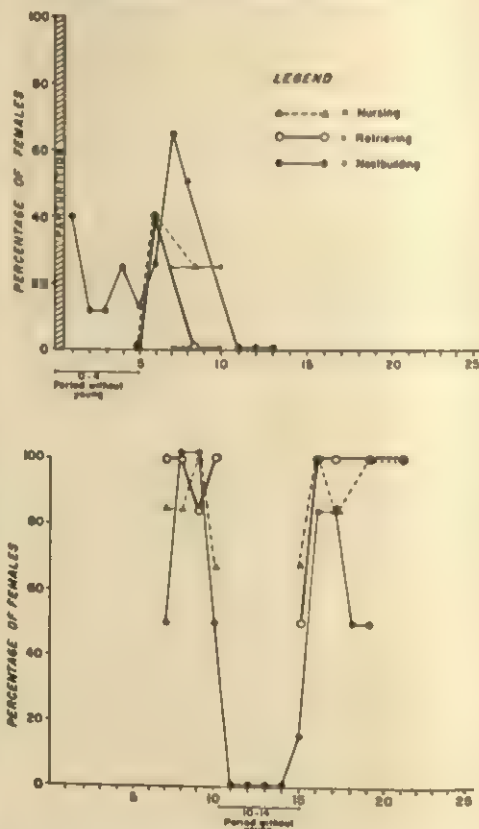


Postpartum waning of maternal responsiveness in mothers whose young were removed at parturition. Percentages of mothers who showed retrieving and nursing in tests with 5- to 10-day-old pups and built nests are shown for one group that was given pups on the beginning of the 3rd day and another that was given pups on the beginning of the 5th day after parturition. Mothers who kept their pups are shown for comparison.

short time (3 to 5 days) maternal responsiveness declined again (FIGURE 4). Failure of lactation was partially responsible for this decline since without feeding the young gradually weakened and became poor stimuli. Moreover, shortly after the period without young many of the mothers initiated estrous cycling, which is normally not resumed until 3 weeks after parturition. It was clear however that as a result of the short period of 2 to 4 days without young immediately following parturition, the mothers were prevented from effectively rearing new litters.

The question arose whether a 4-day period without young begun sometime after parturition would have the same effect on maternal responsiveness. Pups were therefore removed from mothers beginning on the 4th, 10th, and 15th days postpartum and were kept away for 4 days. At the end of this period a litter of 5 test pups (5 to 10 days of age) was given to each mother, and her immediate and subsequent responses to the pups (which the mothers were allowed to rear) were observed. The results of one of these groups (i.e., mothers without young from the 10th to the 14th day postpartum) is shown in FIGURE 4: a period of 4 days without young had a much less drastic effect on maternal responsiveness after maternal behavior had been in progress for 9 days than the same period without young starting at parturition. After the initial tests these mothers resumed their former high level of maternal behavior and in all instances the young were reared until they were weaned. Similar results were found with mothers whose young were removed on the 4th and 15th days postpartum. Removal of the young has a much more drastic effect immediately after parturi-

Figure 4
MATERNAL RESPONSIVENESS AFTER PERIODS WITHOUT YOUNG



Maternal responsiveness of mothers after 4 days without young starting at parturition (upper graph, $n=8$) and at the 10th day after parturition (lower graph, $n=6$). Percentages of mothers who showed retrieving and nursing in tests with 5- to 10-day-old pups and built when young were returned.

tion than after maternal behavior has been initiated and stabilized. After the mother has reared her litter even for 3 days she is able to withstand the effects of removing the pups and eventually she is able to regain her original high level of maternal responsiveness.

Our studies have not yet touched on

the problem of why maternal behavior declines. Presumably the decline of maternal behavior results from the gradual disappearance in the pups of the stimuli which evoke maternal responses. By removing pups from the mother we can simulate this aspect of the normal litter situation. The decline in maternal behavior under these experimental conditions can then be compared to the decline which occurs under normal circumstances. Two groups of mothers were studied: in one group their litters were removed following the 9th day of maternal care; in the 2nd group, following the 14th day. In the first group maternal behavior declined over the next week and by the 15th and 16th day fewer mothers showed nestbuilding and retrieving than among the mothers whose litters remained with them. Nursing remained about the same in both groups of mothers, declining at about the normal time. By contrast the decline of maternal behavior in mothers whose litters were removed on the 15th day, at a time when maternal behavior normally declines, was slowed compared to mothers who were still with their young. A greater percentage of the mothers without young retrieved and nursed test pups on the 18th to 21st days than the mothers who still had young. These findings suggest that after the 14th day pups *actively* reduce the mothers' maternal responsiveness. It is likely therefore that as the young become older they play a role in the decline of maternal responsiveness which contrasts with their role in initiating and maintaining it during earlier phases of the cycle.

We have carried out several experiments in an attempt to test the hypothesis that at a certain age (i.e., in the 3rd week) the young actively reduce the

mother's maternal responsiveness. By giving mothers who were in their 3rd or 4th postpartum day, litters consisting of pups that were older than their own pups (i.e., 8 or 15-16 days older) in exchange for their own litters we expected to induce an early decline in maternal responsiveness. Following the exchange of pups mothers were tested daily with the standard age test young. The decline of nestbuilding was slightly premature (by 2 days) in mothers given pups 8 days older than their own and occurred even earlier (4 days earlier) in mothers given pups 15-16 days older than their own. However, in both groups the effect of the young on the maternal responsiveness of the mother was not proportionate to the ages of the foster young. Retrieving declined somewhat prematurely (by about 5 days) in mothers given pups 15-16 days older in place of their own litters, but again the decline occurred somewhat later than would have been expected on the basis of the pups' ages. It is apparent that the time which has elapsed since parturition also plays an important role in determining when maternal responsiveness declines; usually this is synchronized with the changing effects of the young on maternal responsiveness of the mother. Although these results are not conclusive they do indicate that older pups play some role in the decline of maternal responsiveness.

In summary we have shown that the *maternal responsiveness* of the postpartum female undergoes a cycle during the 3 to 4 week period of maternal behavior. The cycle of maternal behavior in the litter situation is a product of the maternal responsiveness of the mother which changes during the cycle in response to developmental changes in the young.

Stimulation from the litter early in the cycle is necessary for the initiation of maternal behavior and later for its maintenance. Rapid waning of the initial level of maternal responsiveness occurs if pups are removed immediately after parturition; it occurs at a somewhat slower rate if they are removed later in the cycle. There is some indication that the young also play an active role in the waning of maternal responsiveness in the declining phase of the cycle.

DEVELOPMENT OF MATERNAL RESPONSIVENESS DURING PREGNANCY

It is evident that the female is ready to be responsive to pups immediately upon delivery during parturition. We have therefore turned our attention to the development of maternal responsiveness *prepartum* in order to understand the background of the *postpartum* maternal behavior cycle.

Maternal Responsiveness of Virgins. Among any group of female rats a certain proportion are responsive to pups immediately upon their first contact with them. These females, called "spontaneous retrievers," make up about 20% to 30% of the population. Nestbuilding, crouching over and licking the young may also occur "spontaneously." Until recently it was felt that these females represented a special group that was able to exhibit maternal behavior without the proper hormonal stimulation. Wiesner and Sheard⁴⁸ attempted to induce maternal behavior in estrous-cycling females that were not immediately responsive to pups by exposing them to young pups continuously for about 4 days. They found that retrieving and nestbuilding could be evoked in about 30%

of the females, but at the termination of their study the larger proportion of females had not become maternal. We have been more successful in a recent study in which two procedural changes were made. Wiesner and Sheard had allowed the stimulus pups to deteriorate as effective stimuli through lack of feeding; we removed pups every 24 hours and replaced them with fresh pups that had recently been fed. We were able, therefore, to extend the period of continuous exposure to pups to 15 days.³⁶ As a result we found that nearly all females could be induced to show the full complement of maternal behavior (TABLE 1). The latencies for the onset of the various items of maternal behavior ranged from 4.9 to 5.8 days of continuous exposure to pups. With extended testing during continuous exposure to pups it could be shown therefore that there was a basic level of maternal responsiveness present in all females even before the first pregnancy. Cosnier and Couturier⁷ have reported a similar finding using 4 hours of daily exposure to young pups.

We became interested in whether the maternal behavior shown by virgin females was based upon the secretion of ovarian or pituitary hormones as is suspected with regard to the maternal behavior of the postparturient female.^{3, 20, 21, 34, 37} Furthermore we were interested in whether males could also be induced to show maternal behavior and if removal of the gonads would have any effect.

Groups of ovariectomized and hypophysectomized females and intact and castrated males were exposed to young pups according to the procedure that was so effective with the intact females. Maternal behavior appeared in nearly all

Table 1
PERCENTAGE OF ANIMALS DISPLAYING FOUR ITEMS OF MATERNAL BEHAVIOR

GROUP	Retrieve	Crouch	Lick	Build Nest
<i>Females</i>				
Intact (n=14)	93	100	100	100 ^a
Ovariectomized (n=12)	92	83	100	92
Hypophysectomized (n=11)	100	100	100	100
<i>Males</i>				
Intact (n=13)	77	77	85	46
Castrated (n=12)	83	75	83	67

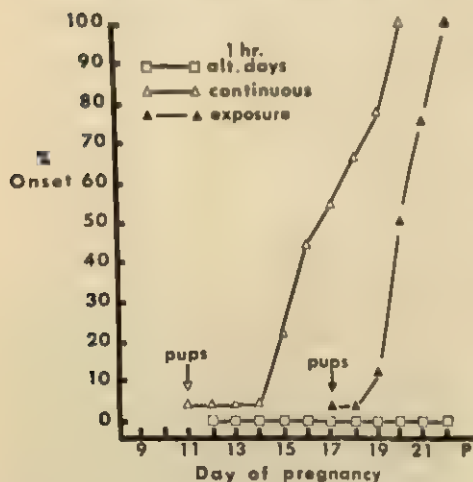
^a Observations made inadvertently on only 10 of the 14 in this group.

the ovariectomized and hypophysectomized females and in a majority of the intact and castrated males (TABLE 1). Except for nestbuilding the percentages of males of both groups that displayed the various items of maternal behavior were not significantly different from the percentages of females of the three groups that displayed maternal behavior. Furthermore the duration of exposure to pups which was required to evoke retrieving and crouching was quite similar among all the groups of males and females. Cosnier and Couturier⁷ have also shown that removing the ovary does not interfere with the induction of maternal behavior by exposure to pups. This study showed therefore that the basic maternal responsiveness of the virgin male and female rat is not dependent upon the ovary nor upon the secretions of the pituitary gland, which are responsible for the release of secretions from the remaining endocrine glands. Maternal behavior elicited from the nulliparous females and from males therefore is of non-hormonal origin and is similar in both sexes.

2. *Maternal Responsiveness of Pregnant Females: "Pregnancy Effect."* As

we have found, it requires an average of more than 4½ days of continuous contact with pups for the estrous-cycling female to become maternal. At the end of pregnancy, however, some 22 days later, the female is immediately responsive to her pups when they are delivered. We can therefore assume that important changes occur in the prospective mother during pregnancy which have the effect of increasing her maternal responsiveness. We have attempted to trace these changes by testing females for maternal behavior from the 12th day of pregnancy onward for one-hour periods on alternate days. The pregnant females were given tests of nursing, retrieving, and nestbuilding using the 5- to 10-day-old pups. Results of the retrieving tests, shown in FIGURE 5, are representative of the results for the other items of maternal behavior and indicate that maternal behavior cannot be elicited from pregnant females in brief tests (one hour) even as late as the 22nd day of pregnancy, just prior to parturition. These results correspond to those of other investigators,^{15, 48} who also have found that pregnant females do not readily show maternal behavior.

Figure 5
RETRIEVING DURING PREGNANCY



Maternal responsiveness in females during pregnancy. Percentages of females showing retrieving in tests with 5- to 10-day-old pups under three conditions: 1-hour exposure to pups on alternate days ($n=17$), continuous exposure to pups starting on the 11th day ($n=10$) and the 17th day ($n=8$) of pregnancy. The curves show cumulative percentages of the group showing onset of retrieving.

Our success in eliciting maternal behavior from estrous-cycling females suggested, however, that the use of a prolonged period of continuous exposure to pups might evoke maternal behavior, thus revealing the maternal responsiveness of pregnant females. The results for

retrieving, shown in FIGURE 5, obtained from two groups of pregnant females that were given pups on the 11th and 17th days of pregnancy,* respectively, and exposed to them continuously, with a daily exchange of the pups for fresh pups, confirmed our expectations. Retrieving was eventually elicited from all of the pregnant females of both groups, starting 4 days after they were given pups in the 11-day pregnant females, and 2 days after receiving pups in the 17-day pregnant animals.** Results similar to these were found for nursing and nestbuilding in both groups.

It was by comparing the latencies for the onset of maternal behavior of the pregnant females to those of the nonpregnant ones of our earlier study that we formulated the concept of a *pregnant effect* on maternal responsiveness. When the latencies for the onset of retrieving of the pregnant females are compared to those of the nonpregnant, estrous-cycling females, we find that the average latency of the 11-day pregnant females (6.33 ± 1.89 days) is not yet significantly shorter, while that of the 17-day pregnant females (3.63 ± 0.99 days) is already significantly shorter ($p < .05$). We obtained our first indication therefore that there is an increase in maternal responsiveness (i.e., shortening of the latency for the onset of maternal behavior) during pregnancy.

* These females were intended as control groups for females that had their pregnancies terminated on the 10th and 16th days and were also given young on the 11th and 17th days of "pregnancy." Therefore, when the two pregnant groups are being discussed alone they will be referred to as 11- and 17-day pregnant, but when they are being compared with other groups they will be referred to as 10- and 16-day pregnant.

** Comparing the 10- and 16-day pregnant groups on the 17th day (FIGURE 5) shows that the performance of the 10-day pregnant females was due to the previous period of exposure to pups. Pregnant females exposed to pups for the first time on the 17th day do not show retrieving whereas pregnant females that have been exposed to pups for 5 days previously show retrieving in about 55% of the cases.

Effect of Terminating Pregnancy on Maternal Responsiveness: "Termination of Pregnancy Effect." In the study described above, pregnancies were not terminated as a result of the exposure to test pups and display of maternal behavior. Daily vaginal smears indicated that pregnancy continued undisturbed, and parturitions were normal in all instances. Following parturition maternal behavior appeared normal although, for reasons that are not relevant to our present discussion, many of the newborn died. Dr. Dale F. Lott and I reasoned that maternal behavior might appear more readily if the pregnancies were terminated by hysterectomy or Caesarean-section. It has already been reported that females show maternal behavior within a few hours after exposure to young following Caesarean-delivery as early as the 19th day of pregnancy.^{15, 24, 43}

Our plan was to perform operations to terminate pregnancy at progressively later times during pregnancy, followed by our usual tests of maternal behavior, using 5- to 10-day-old pups that remained with the females continuously. We found that under these conditions the latencies for the onset of retrieving gradually declined as the operation was performed after increasing durations of pregnancy.²² The first significant decline in latency for the onset of retrieving occurred in the 10-day group of operated females and a further significant decline in the latency for retrieving occurred when operations were performed on the 16th-to-19th day of pregnancy (TABLE 2). A little more than 24 hours of exposure to pups (48 hours after the operation) was all that was necessary to elicit maternal behavior (i.e., retrieving) from females that had already gone through

16-to-19 days of pregnancy before its termination.

Table 2
LATENCIES FOR THE ONSET OF RETRIEVING
AFTER HYSTERECTOMY OR CAESAREAN-
SECTION DELIVERY AT VARIOUS
TIMES DURING PREGNANCY

Day of Operation	N	Onset of Retrieving Mean Latency in Days ^a	SD
19	8	2.25	0.28
16	16	2.31	0.67
13	9	3.67	1.35
10	11	4.18	2.01
8	8	6.37	1.05
Nonpregnant	15	6.78	2.80

^a Latencies are given from day of operation. Pups were presented starting 24 hours later.

Our results are to be viewed in conjunction with a recent study by Moltz, Robbins, and Parks²⁴ which reports that following Caesarean-section delivery performed just prior to parturition (i.e., 22nd day of pregnancy) only a few hours of exposure to pups are required for the appearance of maternal behavior. The shortening of the latency for the onset of retrieving (and other items of maternal behavior) after experimental termination of pregnancy therefore continues after the 19th day, resulting in only a brief delay in the appearance of maternal care on the 22nd day.

In the 16-day pregnant group, terminating pregnancy shortened the latency for the onset of retrieving—a latency that was already significantly reduced by the pregnancy effect (TABLE 3). This additional increase in maternal responsiveness we have labeled the *pregnancy termination effect*; it appears as a result of the operation ending pregnancy (as

well, of course, with subsequent stimulation by pups).

When does the pregnancy termination effect first appear during pregnancy? The 10-day pregnant females are the first to show an increase in maternal responsiveness due to the termination of pregnancy (TABLE 2). The latency of the 8-day pregnant females, after they were hysterectomized, was equal to that of the nonpregnant females, so evidently the operation had no effect upon their maternal responsiveness. The 10-day group while pregnant had the same latency as the nonpregnant females (as well as the 8-day pregnant, operated females) but after hysterectomy there was a significant reduction in the latency for the onset of retrieving (TABLE 3).

Summarizing, we can distinguish three sources contributing to the appearance of maternal behavior postpartum. In the estrous-cycling female there is a basic level of maternal responsiveness which is nonhormonal in origin. During the first 10 days of pregnancy there is no significant change, but in the following week and a half maternal responsiveness

gradually increases and the pregnant female more readily become maternal towards pups to which she is exposed continuously. Normally pregnancy is not terminated before parturition, but if it is experimentally terminated then an additional effect on maternal responsiveness is revealed as early as the 10th day of pregnancy. Maternal responsiveness increases after hysterectomy at this early point in pregnancy.

What is the basis for the increase in maternal responsiveness after pregnancy is terminated by hysterectomy (or Caesarean-section delivery). Ovarian hormones (estrogen and progesterone) normally play an important role in terminating pregnancy; the mother undergoes an estrous cycle (postpartum estrus) a few hours after parturition.⁴⁴ Activation of the ovary by experimental termination of pregnancy might be the basis for the increase in maternal responsiveness.

To investigate this, two groups of pregnant females (10-day and 16-day pregnant) were hysterectomized and simultaneously their ovaries were re-

Table 3
LATENCIES FOR THE ONSET OF RETRIEVING OF 10- AND 16-DAY PREGNANT FEMALES EXPOSED TO PUPS AFTER VARIOUS TREATMENTS

(mean latency in days from the 10th or 16th day of pregnancy)

GROUP	TREATMENT			
	Pregnant	Hysterectomy + Ovariectomy	Hysterectomy ^a	p value ^b (3)-(4)
10-day pregnant	7.33±1.89	6.42±3.02	d 4.18±2.01	<.05
16-day pregnant	c 4.63±0.99	d 4.57±2.02	d 2.31±0.67	<.005
p value ^b	<.005	=.05	<.005	

^a Some animals were hysterectomized and others had only their fetuses and the placentas removed by Caesarean-delivery. Thus far, these two procedures have given the same behavioral results.

^b Comparisons between means of columns 2 and 3 were not significant (t-test).

^c Mean latency is significantly shorter than the latency of virgins at the .05 level of confidence.

^d Mean latency is significantly shorter than the latency of virgins at the .02 to .005 levels of confidence.

moved. They were given test pups 24 hours after the operation and latencies for the onset of the various items of maternal behavior were observed while they were exposed to pups continuously. In both groups the increase in maternal responsiveness (i.e., shortening of latencies for the onset of retrieving) which followed hysterectomy alone failed to appear (TABLE 3). The latencies of both groups were similar to those of 10- and 16-day pregnant females and were significantly longer than those of females that were only hysterectomized on the 10th or 16th day of pregnancy.

These findings, although obtained from 10- and 16-day pregnant females, are related to those of Jost¹² and Moltz and Wiener,²³ who studied the effects of ovariectomy performed on the 19th to 21st day of pregnancy. Maternal behavior was observed by them following parturition or Caesarean-section delivery. These investigators found that 50% of the mothers failed to initiate maternal behavior and their litters died or were cannibalized. It will be recalled that we found that maternal behavior was *delayed* by ovariectomizing 10- and 16-day pregnant females that were already hysterectomized but that it eventually appeared. We would expect therefore that females even further along in pregnancy at the time of the Caesarean delivery (or parturition) would be more responsive to pups than our females, though there might still be a delay in the appearance of maternal behavior because of the ovariectomy. Unfortunately the mothers in these two studies were not provided with new litters after the original ones died so that we cannot determine whether maternal behavior would have appeared eventually. Nevertheless it is reassuring that in analyzing the fac-

tors which affect maternal responsiveness earlier in pregnancy we find that our results are in basic agreement with those derived from studies of the maternal responsiveness of mothers around parturition.

HUMORAL BASIS OF MATERNAL RESPONSIVENESS

1. *Direct Evidence of a Humoral Basis for Maternal Responsiveness After Parturition.* Several recent attempts to induce maternal behavior in the rat by means of various hormones (estrogen, progesterone, and prolactin) injected directly into virgin or experienced females have not yielded results that would increase our understanding of the hormonal basis of this behavior.^{3, 20, 21} Injected hormones (prolactin and oxytocin) have failed also to *maintain* maternal behavior in mothers that have become maternal after parturition or have been made maternal by Caesarean-section delivery of their fetuses several days before normal parturition (Rosenblatt, unpublished). There remains the conviction, nevertheless, that maternal behavior in the rat is based upon hormones and this is supported by the success in inducing nestbuilding in the mouse with progesterone^{13, 14} and in the hamster with estrogen and progesterone.^{30, 33} Some success has been reported in inducing maternal nestbuilding in rabbits using a combination of hormones [stilbestrol, progesterone, and prolactin].⁴⁵

We felt therefore that the problem should be approached in a different manner with procedures that remain close to the natural conditions under which maternal behavior normally appears at and shortly after parturition.⁴¹ By removing blood from postparturient mothers

known to have become maternal within the past 48 hours and injecting the blood plasma into virgins, we hoped to establish that this plasma carries substances capable of inducing maternal behavior in virgins.

Blood was removed from mothers and the plasma was injected into the virgins (in the femoral vein). Shortly afterwards (one hour) the virgins were given pups and were tested for maternal behavior. The pups remained with the virgins and were exchanged for fresh ones daily. As control groups we used a group of virgins that were injected with blood plasma taken from females in the proestrus phase of the vaginal estrous cycle and another group of virgins that received blood from females that were in the diestrus phase of the vaginal estrous cycle. The recipient females were in the same phase of the estrous cycle as the donors. A further control group consisted of virgins injected with saline solution.

Maternal blood plasma proved highly effective in reducing the latency for the onset of retrieving (and the other items of maternal behavior) while plasma taken from females in various phases of the estrous cycle and saline solution had no significant effect on the latency for the onset for retrieving among virgins (TABLE 4). It is remarkable that a single injection of about 3½ cc. of blood plasma taken from a maternal female could have such a rapid and marked effect on the maternal responsiveness of the virgins, causing them to become maternal towards young after an average of only 48 hours of exposure. It is our belief that the continuous interchange of blood between a maternal female and a virgin would significantly reduce the latency for the appearance of retrieving in

Table 4
MEAN LATENCIES (DAYS)
FOR THE ONSET OF RETRIEVING

GROUP	N	Mean	SE
Maternal plasma	8	2.25	0.97
Proestrus plasma	8	4.62	1.21
Diestrus plasma	8	7.00	2.96
Saline	8	4.00	1.41

the virgins and we are presently engaged in developing a technique for accomplishing this.

This study provides direct evidence that there is a humoral basis for maternal responsiveness in the postparturient mother. It remains for us to identify the effective components of the blood plasma which induce maternal behavior in virgins. We are interested also in how the blood plasma induces maternal behavior in the virgin, whether by acting upon the pituitary gland or other endocrine glands or by acting directly upon the neural substrate of maternal behavior.

DISCUSSION

Our discussion will be limited to outlining the principal phases in the development of maternal responsiveness in the rat and to an analysis of the factors which are important in each phase and in the transition from one phase to the next. What emerges from our studies is the pivotal position of parturition in the development of maternal responsiveness in the rat. Before parturition maternal responsiveness develops largely under the influence of endogenously-stimulated processes associated with pregnancy; after parturition its development is dependent upon stimulation arising from the young. The transition from pre- to postparturition control of maternal re-

sponsiveness is normally initiated during parturition.³⁷

Our studies have shown that the level of maternal responsiveness found in the parturient female originates from the earlier basic maternal responsiveness of the estrous-cycling female. The non-hormonal origin of this maternal responsiveness has been demonstrated by its appearance in females after hypophysectomy or ovariectomy. Nonhormonally-aroused maternal responsiveness has been reported in the mouse and hamster.^{4, 16, 17, 26, 27, 31-38} Studies in these species are further along in showing the similarity between the maternal behavior of the virgin and lactating female and in exploring the origins of nonhormonally-aroused maternal behavior.^{27, 33, 38}

In the estrous-cycling female maternal behavior appears after 6 days of exposure to pups but in the parturient mother maternal behavior appears immediately upon contact with the newly born young. Our studies have shown that the mother's condition at parturition is established during pregnancy. We have distinguished two major influences in the development of maternal behavior: a "pregnancy effect" which is defined as the change in maternal responsiveness during the time the female is pregnant, and a "pregnancy-termination effect" which is defined as the change in maternal responsiveness that results from the experimental termination of pregnancy by hysterectomy or Caesarean-section or presumably from the natural termination by parturition. We shall discuss these two influences on maternal responsiveness.

The "pregnancy effect" is indicated in the greater maternal responsiveness of the late pregnant female (16-day) over

the mid-pregnant female (10-day) shown by the shorter latency for the onset of retrieving and other items of maternal behavior in response to continuous exposure to pups, in the former. A change from the level of maternal responsiveness of the estrous-cycling female occurs between the 10th and 16th day of pregnancy, although we have not yet measured this change at very many points during pregnancy. Until more points during pregnancy are measured we cannot correctly evaluate the level of maternal responsiveness of even the points which we have studied (10th and 16th days of pregnancy), since pup exposure over a number of days gives results which measure not only the maternal responsiveness at the start of the exposure but also any changes which occur, independent of the exposure, during the period of exposure. Nevertheless we can safely say that maternal responsiveness increases during pregnancy, and moreover, the technique for measuring maternal responsiveness does not itself disturb the pregnancy nor affect maternal behavior after parturition.

The pregnancy-termination effect produces an increase in maternal responsiveness starting even earlier than the pregnancy effect: experimental termination of pregnancy at the 10th day produced a significant increase in maternal responsiveness even before there was any indication of an increase due to the pregnancy effect. Earlier, on the 8th day, experimental termination of pregnancy had no effect on maternal responsiveness. This effect therefore arises between the 8th and 10th day of pregnancy. In the 16-day group of pregnant females the pregnancy-termination effect (a shortening of the latency for retrieving by an average of about 2 days) was

added to the pregnancy effect (about 2½ day shortening of the latency for retrieving) to produce an average latency for retrieving of a little more than 2 days.

There is evidence that both the pregnancy effect and the pregnancy-termination effect combine at parturition to produce the characteristic high level of maternal responsiveness of the postparturient female, from which arises the initiation of maternal behavior. The evidence is of a negative sort derived from studies^{12, 28} in which pregnant females were ovariectomized just prior to parturition, abolishing, as we have shown, the pregnancy-termination effect. In both studies about 50% of the females showed maternal behavior after parturition, an indication we believe of the high level of maternal responsiveness reached as a result of the pregnancy effect. An equal percentage of the females failed to show maternal behavior and either abandoned their young or cannibalized them. For these animals, abolishing the pregnancy-termination increase in maternal responsiveness by removal of the ovaries left them at a level of maternal responsiveness that was not high enough to enable them to initiate maternal behavior. In our studies with 16-day pregnant females in which the ovaries were removed at the experimental termination of pregnancy, we found that the onset of maternal behavior was *delayed* but not entirely prevented by removing the ovaries. Maternal behavior was eventually elicited by the test pups and the latency was equal to that of the pregnant female; in other words, it was the latency of a female who is under the influence of the pregnancy effect alone! Unfortunately the postparturient mothers that failed to initiate maternal behavior in the studies

described above were not given fresh young after the original ones died and therefore we are unable to verify our findings with the 16-day pregnant females on the postparturient females. Were they given fresh young, we would predict that those postparturient mothers who failed to initiate maternal behavior immediately would have done so after a short delay.

Normally the mother initiates maternal behavior at her first contact with the newly born young under the influence of the high level of maternal responsiveness which has been developed during pregnancy and parturition. Several studies^{15, 24, 48} have shown that the initiation of maternal behavior is not prevented by delaying the mother's initial contact with newborn by performing a Cesarean-section and presenting her with newborn several hours after recovery from the operation. It is likely that the high level of maternal responsiveness that is established during pregnancy, including the pregnancy-termination effect, is sufficient to carry the mother over a short period without young. Since the young retain their attractiveness to mothers for some time after birth, maternal behavior can be initiated at this time.

Nevertheless parturition does represent the time when the two major influences upon maternal responsiveness that have been in effect up to that time come to an end. Insofar as the pregnancy-termination effect is dependent upon the ovaries, this effect must disappear after parturition since removing the ovaries within the first 12 hours *after* parturition does not have any effect on subsequent maternal behavior. It is the young, our studies indicate, that maintain the maternal responsiveness of the mother after parturition. Their removal at parturition

causes a rapid waning of maternal responsiveness. Thus the mother's level of responsiveness at parturition is maintained and developed further as a result of stimulation provided by the young.

Postpartum maintenance of maternal responsiveness is at first closely dependent upon the young. It becomes somewhat less intimately tied to this stimulation as early as the third day after parturition when there is only a slight reduction of maternal responsiveness following a 4-day separation from the young. After the return of pups, maternal responsiveness rapidly returns to its previous high level.

We can speculate that the older pups in our studies on the decline of maternal responsiveness did not have the expected effect of prematurely diminishing the maternal responsiveness of mothers who themselves were at the early part of maternal behavior cycle because we failed to take into account the impetus imparted to the maintenance of maternal responsiveness during the initial period of contact with newborn. In one study, not yet cited, we found evidence of this in the behavior of the older pups (8-days older than females own litter). These pups were retrieved by the mother whenever they were out of the nest; as a result, they remained huddled in the nest for several days longer than they normally would had they remained with their own mothers.

Nevertheless we propose that older pups have the effect of reducing the maternal responsiveness of mothers at the corresponding phase of the maternal behavior cycle. Their effect on the mother is based upon two features of their development: first there is the disappearance of stimuli which formerly evoked maternal responses (e.g., immobility,

etc.) and second, there is the appearance of a variety of new responses to the mother (e.g., feeding, play, etc.) which in turn alters her behavior towards them and, as a consequence, causes a reduction in her maternal responsiveness.

IMPLICATIONS

The present paper is to be viewed as a contribution to the analysis of maternal behavior in the rat. The development of maternal responsiveness, as we have seen, extends over nearly two months of the female's life. We feel that approaching the analysis of maternal behavior as a developmental problem, rather than as an analysis of innate as against learned components, has enabled us to take the first steps in outlining the principal phases of its development during the reproductive cycle of this species and to indicate the major influences which give rise to the sequence of developmental phases.

Three implications can be drawn from our studies of maternal behavior in the rat which have value for the analysis of maternal behavior in other species, including humans. Maternal behavior is a developmental phenomenon in which the appearance of care of the young following delivery has characteristics which arise from earlier periods of life and in particular the immediately preceding period of pregnancy. Before pregnancy, elements of maternal behavior reside in the female; and during pregnancy, physiological (i.e., hormonal) changes increase the female's responsiveness to stimulation by young. Delivery itself contributes to a further increase in maternal motivation and provides the initial contact with young. The importance of this contact lies in immediate effects—the elicitation of maternal be-

havior—and in long-term effects—the maintenance of maternal responsiveness.

A second implication is that the mother's maternal condition and details of her behavior are governed by stimuli from the young received during the frequent mother-young contacts involved in maternal care. Alterations in the young may affect the care which they receive because of their effect upon the mother's motivation and behavior, and this may in turn further alter the behavioral development of the young. Mother and young are synchronized with each other: changes in the mother's behavior are related to changes in the physical and behavioral capacities of the young and any disturbance of this synchrony arising either from within the relationship (e.g., maternal overprotection limiting the development of the young) or from outside of it (e.g., enforced separation for a period) is likely to disrupt the synchrony with important consequences for the mother's behavior and the behavioral development of the young.

Finally, maternal behavior has a natural end which, in line with the synchronous nature of the mother-young relationship, is based upon developmental changes in the young. These changes gradually eliminate stimuli which elicit maternal behavior and sustain the mother's condition and, in addition, introduce new stimuli from the young which no longer evoke maternal behavior. The relationship between the mother and her offspring changes in the process of weaning, leading on the one hand to the decline of the female's maternal behavior and on the other hand to the attainment of independent functioning on the part of the young.

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COGNITION AND SOCIAL ADAPTATION

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Piaget's demonstration interview technique was used to test the level of development of the thinking capacities of socially dissonant children in a disadvantaged area. His theory of groups and groupings were taken as a frame of reference in interpreting the results, which showed a severe developmental lag in these children. The findings are discussed in terms of effects of cognitive patterns on social adaptation in urban areas.

Until a few years ago clinical diagnosis of socially dissonant behavior was assumed to be related to a lack of ego controls which allowed dyssocial impulses, originating in either the instinctual or affective life of the individual, to be translated into action. Research, at least in the United States, was focused largely on the nature of the impulses and the development of controls in the child's early relationships. Special attention was paid to the adequacy of nurturance in the mother-child dyad, which was thought central to the development of the affective basis of impulse intensity, and to the process of identification with the parent of the same sex, which was

thought central to the development of the necessary superego or conscience controls.

Within this frame of reference much was learned that seemed useful in efforts to understand and treat dyssocial behavior in children and adolescents, but treatment results were often equivocal and comparative studies (unpublished) of treated and nontreated children with adequate samples showed no significant difference in outcome.

The trends have followed the development of psychiatry in general: Protagonists of the psychodynamic point of view have had to rely on individual case studies selectively presented to prove

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their point. Others have tended to seek explanations confined to the biological makeup of the individual, assuming an "organic" etiology for "impulsive" dyssocial behavior. Such concepts as psychomotor epilepsy or assumptions of subtle unexplained changes in brain function were based on gross tests such as the EEG. Many, tired of the psyche-soma dichotomy, assumed that both played a causal role. It is safe to say that although concepts derived from this work did help some children, few if any startling insights have accrued from it in the past several years and many children have failed to respond to sometimes Herculean efforts to change them. The end result of this failure has been that although professionals have been able to maintain some semblance of self-esteem by becoming expert in the application of labels, their effectiveness often ends there.

The reason for this failure is becoming clear largely, we think, as a result of pressures accumulating outside the halloved work arenas of behavioral scientists—in our communities, especially in our cities. Large numbers of city dwellers are behaving in ways that would be considered dyssocial in any society. We know, for example, that many who participated in the recent riots in urban ghettos did so with very little understanding of the ideological issues involved.³ Our cities are filled with many people who, poverty stricken and disenfranchised, drop out or are pushed out from school, from jobs, from family, from social life in general. Some, from birth on, have simply been excluded by prejudice and poverty from many areas of participation in community life. It is clear that the life state of these human beings has been determined by complex

forces that cannot be explained by hypotheses confined to adequacy or inadequacy of nurturance in childhood. In particular, their difficulties will not be explained by psychiatric labels, the application of which only adds to their social problems. Children who habitually disrupt their class in school are not all psychopaths, or psychotics, or retardates, or brain damaged. And to say that they suffer from a behavior disorder seems to us the ultimate in tautological irony.

In the last few years there has emerged a new and more holistic way of looking at those phenomenon in which the behavior of individuals and the demands of our society clash. A considerable number of behavioral scientists has begun to use an ecological systems approach in attempting to analyze the interactions between individuals within the family, the transactions between the family constellation and the different systems constituting the community, and the relationships of the community to the larger outer world.³

Instead of focusing mainly on "illnesses" and their classification according to labels describing "pathology," the relationships between the troubled person and all the ecological systems which surround him, his understanding of them, and his capacity to function within them, are now the target of the clinical work-up. Transactions between subjects, siblings, family, school, neighborhood, welfare systems, language groups, culture groups, etc., are investigated to ensure that the phenomena in question are clearly understood. Seen within this framework, it is evident that the individuals' capacity to function in the highly organized and complex systems of our modern urban society will depend, on the one hand, on how well he is able to

understand and differentiate these systems and, on the other hand, on whether he has developed the cognitive tools he needs to identify, classify, and integrate the messages he receives from them.

To quote a previous paper of one of the authors²: "In today's urban world, the interface between the individual man and his immediate environment is becoming increasingly complex. What is needed if we are to deal with that interface, is a fairly *detailed* map of the various arenas in which the urban dweller must be able to function if he is to become and remain a participant in the life of his community, and a *clear model* of the sequential process of cognitive development through which he must go if he is to internalize a well-differentiated view of those arenas and develop the tools he needs for participating in them."

Although we are equally concerned with both sides of this interface, we wish to address ourselves in this paper to the latter subject—the development of a clear model of the sequential process of cognitive development.

GENERAL DESCRIPTION OF PROJECT

Using Piaget's theory of development as a framework, we have gathered some observations about the level of development of the thinking capacities of socially dissonant children in the geographical area served by our program. In this exploratory study we tested routinely all cases referred, regardless of reason for referral, in order to learn: (1) What modifications of Piaget's testing techniques would be necessary in a population such as ours. (2) Some idea of the type of intellectual structures at the disposal of our subjects. (3) Whether this type of test interview would give information helpful in the development of

curricula for use in therapeutic intervention.

We wish to emphasize that the circumstances of data collection are not those of a well-designed research experiment. Our observations were collected from testing done routinely as part of our overall service program for school-age children referred to us for many reasons. Most of standard psychiatric labels are to be found in the group. Almost without exception, children referred were having serious trouble in school, and most came to our attention as a result of a referral initiated there.

The only interviews excluded from these observations are those done with an interpreter in which there was a question of accuracy and those of children who were markedly retarded in development by any standard. We have gathered 57 cases of ages ranging from 6 to 14, the bulk of these between 7 and 11.

THE SETTING

The Gouverneur Health Services Program of Beth Israel Medical Center is located on the Lower East Side of New York City. The program provides biological, psychological, and social health care to the medically indigent of a district housing 144,000 people. Approximately 100,000 are considered medically indigent. A large percentage of this group receives public assistance.

The population served is remarkably diverse in ethnic and cultural background. Roughly, 23% is Puerto Rican, 8% Negro-American, 9% Chinese, and 60% would be classified white-American, including significant numbers of persons of Jewish, Polish, and Italian origins.

The program, which is partially financed by an OEO grant, is known for

its development of new systems of health care delivery specifically designed for the disadvantaged. The portion of the program charged with providing psychological and social health care, within which the exploration was carried out, is known as the "Applied Behavioral Sciences Program."

THE FRAME OF REFERENCE

Piaget¹⁵ has provided us with a description of the sequence of cognitive development which we will outline briefly here in order to make clear the context within which all our data has been gathered.

Piaget has shown the development of intelligence to be roughly divided into four stages, each characterized by one type of equilibrium, and each tending towards greater mobility and reversibility of mental operations. The first stage is the *sensory-motor* (0-2), during which the infant develops and coordinates his sensory-motor actions into complex organizations and thus starts differentiating between his self and his environment. During this stage, no symbolic representations are yet in use.

This gradual differentiation is continued in the next stage, which Piaget calls *intuitive or egocentric*: (2 to 7-8/MC standards). The symbolic function (symbolic play, language, etc.) appears at this stage, which is characterized by a prelogical and egocentric thought organization. We will describe later the limitations entailed, for they apply in large measure to what we have observed in our population.

The child's capacity to structure his environment becomes more flexible when the stage of *concrete operations* is reached (7-8 to 11). Thought processes become reversible, and the child now has

at his disposal a variety of cognitive structures called groupings. Such groupings are systems that can be easily recognized from the operations the child is able to perform, especially conservation. Until there are groupings, there is no conservation.

During the last stage, the child becomes able to manipulate not only reality data itself but also propositions applying to the data. He reaches the fourth stage of *hypothetico-deductive thinking*: (11-adult). Normally, the adolescent is able to manipulate all the possible relations between a given set and then check through by deduction or experimentation to find out which are true or most probable. Variables are handled according to combinatorial analysis.

Piaget states that during the first two stages,⁷ thought is either in state of disequilibrium or in a very unstable equilibrium. Every new acquisition modifies the notions held previously or produces contradictions. When the child reaches the operational stage, however, at which time the integrating frames are constituted by the different groupings, the equilibrium is such that new information can be assimilated without upsetting the past structure in its totality. New elements integrate themselves harmoniously into the previous context. They complete or add to the context or, perhaps, correct an error without requiring a general reconsideration of the relationships as they are already grouped.

The qualitative conditions of these groupings¹⁵ are five in number: composition, reversibility, associativity, identity, tautology—the most remarkable being reversibility. Composition may be applied to action, perception, habit, but these take place in one way and are not reversible; e.g., learning to perform the

inverse movement is learning another kind of movement and not a reversible process.

The preoperational thinking of the child, before groupings are constituted, has a characteristic structure. Piaget describes the many ramifications of this prelogical mentality under the overall label of "egocentrism."⁸ Egocentric or prelogical judgment is *transductive*; that is to say, because of lack of mobility, reasoning proceeds from particular to particular, from preconcept to preconcept. It is *intuitive* and not yet deductive; the child is likely to jump to conclusions without going through the necessary steps of deduction. It is *syncretic*; the child will link elements together in an immediate global and overall fashion instead of doing so according to the logical structure of these elements, because he is unaware that they fall in the same category. Piaget describes this as fusion between elements. Egocentric thought is also *juxtapositional*: one element will be placed beside another without taking into account the causal relationship. This is particularly evident in the structure of language used by young children.¹² Connections between groups of words are very seldom of a causal nature (such as: since, therefore, because) but tend to be merely additive (and, and, . . .). Preoperational thought tends to take the form of a *mental experiment*: even if action is not actually performed, representations in thought are very close to action and mental process proceeds from configuration to configuration in a very static, concrete, irreversible manner.

Egocentric thought *centers on one single feature of the object at a time*,

thus neglecting other important compensating aspects. This is closely related to the way the child structures his environment. The ability to shift rapidly from one aspect of a situation to another allows a much more thorough and objective understanding of that situation. It is also, of course, related to irreversibility of thought processes. Without reversibility, the child cannot construct hypotheses and syntheses, since once he has started in one direction, he cannot cancel that operation by the reverse operation and start anew. Irreversibility is also manifested in the child's inability to conserve physical invariants such as mass and weight.*

METHOD AND TECHNIQUES

The clinical interview technique originated by Piaget was used throughout all parts of the interview. The aim was to interpret the underlying workings of the child's mind rather than to consider the nature of the responses themselves.

The interview included systematically:

1. Tasks of conservation of number, mass, and liquids.¹⁴
2. Seriation (ordering according to differences).¹³
3. Classification:
 - a. Classifications of shapes and colors (ordering according to similarities).¹³
 - b. Quantification of inclusion (another classification task involving understanding relations of quantity).¹³
4. Others which were added when time and motivation permitted: such as, conservation of length, distance, volume.⁷

* This summary is very incomplete and schematic. More information is available in Flavell,⁷ or Inhelder,⁸ or Piaget.^{12, 13, 14}

Since we are reporting the results only of tasks of conservation and classification, we will briefly describe only those techniques. A more detailed description can be found in Piaget "le développement des quantites physiques"¹⁴ and "la genese des structures logiques elementaires."¹⁵ We used the interview forms which Piaget uses. However, when the questions involved were not understood by the child, we felt free to change the form so as to be understood. Also, when it seemed to us that the child did not respond because he did not know what was expected, we used clue-giving versions of the same form.

CONSERVATION OF NUMBER

Step 1

1 set of 7 tokens is lined up by the tester. The child is then asked to take an equal number from a boxful.

Step 2

When the child indicates that the 2 sets are equal, one line is stretched further apart and the question is asked whether the two sets are still equal. Variations of the question are: "Are we still equally rich?" "Do we still have the same amount?" or "Can we still buy as many pieces of bubble gum?"

CONSERVATION OF MASS

Two identical balls of plasticene (A and B) are used. Once the child has affirmed his belief that the two balls are equal in quantity (variation: "the same amount" or "as much stuff to eat"), ball B is transformed into the shape of a hot dog and the child is asked whether "we still have the same, more, or less dough" in A and B, and why, (or variations of the question). After a return to the original ball shape, B is successively transformed into a pancake and into about 10 crumbs and the same question is asked.

CONSERVATION OF LIQUIDS

Two identical beakers (A and B) are filled with equal amounts of blue and red colored water by the child. The water in beaker B is then poured into a longer and narrower beaker

(L). The child is asked whether "we still have the same quantity of colored water." (Variation: Are we both happy with how much juice each of us has got now? Why?) Three types of beakers are used successively.

Our criteria for conservation is the affirmation that number, mass, quantity, etc. have remained invariant throughout the number of transformations involved in that test.

We consider both spontaneous and elicited conservational judgments as indications of operability; conservational answers that do not resist counter-suggestions are rated as fluctuant.

CLASSIFICATION

Material and instructions were aimed at observing spontaneous classification schemas:

1 red set	} of	3 small circles; 3 large circles;
1 blue set		4 large squares; 2 small squares;
		3 triangles; 1 rectangle.

Step 1

The child is asked to "straighten out the pieces." Two boxes are offered. If the schema he offers is not a classification, the child is allowed to continue his procedure. Then instruction for step 2 is given.

Step 2

"Sort out the pieces so that one kind goes in one box and the other kind in the other box, or so that those that belong together get put away in the same box."

Step 3

The child's capacity to shift is tested. An attempt is made to elicit classification of the material according to a second criteria.

SERiation

The child is given 13 sticks, 1/4 inch apart in length in a graded series, but now mixed up. He is instructed to put them in order.

QUANTIFICATION OF INCLUSION

The child is given a box containing yellow and blue wooden beads. There are 2 blue and 8 yellow.

Step 1

The child is allowed to or, if necessary, helped to familiarize himself with the material.

Step 2

The child is asked: "If you make a necklace with all the beads made of wood, and I make a necklace of all the blue beads, who can make the longest necklace?"

SIGNIFICANCE OF THE TESTS

Conservation: Millie Almy¹ states in her book *Young Children Thinking* that "the ability to conserve is revealed when the child grasps the mathematical idea that N is not changed when a set of objects is partitioned into subgroups and the physical idea that mass substance does not change when the shape or appearance of an object is transformed."

For Piaget the appearance of this ability is really the cornerstone of the child's development. It indicates the *transition* from intuitive thought, egocentric in nature, to *concrete logical thinking*, more objective and more socialized. It indicates that the child now has at his disposal operational groupings with which he can organize his environment.

As we have seen, cognition prior to conservation is dominated by perception, proceeding from one particular instance to another. Thought processes center alternately on one relation or another without relating them to a whole. Contradictions, therefore, are out of awareness.

The conservational child, on the contrary, can deal with several relationships at the same time. "He can compare, explore similarities and differences, and he has at his disposal a system of integrated operations with which he can organize and manipulate the world around him."⁷ As Millie Almy puts it, "the information from his experience is mentally registered in such fashion that he can readily

think his way through a logical sequence, moving forward and backward at will. He has no difficulty in canceling out the effects of changes in order to focus on the elements of an experience that have remained unchanged."

Classification: As Piaget defines it, "An operation is an internalized action. Its fundamental characteristic is its reversibility." In the process of classifying, adding, etc., a transformation perceived in the physical environment can be cancelled out mentally by the reverse action. By presenting the child with tasks of classification, we are able to analyze in more detail the child's operational activity. "Each task requires the same back and forth mobility or operational activity, but different tasks are helpful in finding out the degree of that operational mobility and where difficulties in the actual process lie."

RESULTS

Conservation: Behavior of the subjects has been classified into three groups; preoperational, operational, and transitional.

TABLES 1 and 2 indicate percentages of children who were operational or transitional on the various tests of conservation according to age.

These results indicate that it is not until the age of 10 that nearly all of these subjects became operational in the conservation of number (easiest in the hierarchy). At age 10, 50% of these subjects were also operational in the conservation of liquids; and 60% were transitional in the conservation of mass.

If we consider only the two very closely related tasks of conservation of liquids and mass, it appears that 10 is the age of transition for socially dissonant children from the low-income pop-

Table 1
% OF CHILDREN OPERATIONAL
IN CONSERVATION OF
NUMBER, LIQUIDS, AND MASS (N=57)

Ages	Number	Liquids	Mass
7	10	30	0
8	55	41	33
9	75	44	44
10	100	50	28 ^a
11	75	100	60

^a Most Ss are in the fluctuant category.

Table 2
% OF CHILDREN TRANSITIONAL
WITHIN TEST

Ages	Number	Liquids	Mass
7	0	0	0
8	0	8	8
9	0	22	11
10	0	14	56.8
11	(15)	0	15

ulation of our area. At age 10, 75% or more of the subjects are either operational or transitional.

Classification: The spontaneous classifying behaviors we observed were: figural collections and nonfigural collections for the 7-year-olds (who produced simple clusters of items); collections, subclasses, and classes for the other ages.

What we found most interesting was the persistence in all subjects of the most primitive ways of approaching the task. In the older group (10 and 11), many children who in the end managed to separate the different classes of objects, started by using, in turn, all the patterns typical of earlier stages, such as figural collection and subclasses. In some subjects we observed the entire series of classification behaviors described by Piaget across all four stages.

The 11-year-olds were all able to classify materials according to one criterion,

but only one-third of them were able to shift to another criteria (e.g., color to shape). They seemed to be unable to shift from their initial focus on one criterion. If they first discovered shape as the classifying criterion, it was next to impossible to convince them that there might be another way, even when the classification process was started for them using color. Most of the time they would continue to use the new criterion to classify two or three elements, and then return to the original criterion.

Only four children out of the whole sample were able to introduce correct relations of quantity between each complementary class and the whole in which it is included. Although they understood that there were wooden beads that are blue and wooden beads that are yellow in the box, they were unable to shift rapidly between the two qualities of color and wood and could not tell if we had more wooden beads or more blue beads. In other words, although this group had moved into the operational stage according to the criteria of conservation capacity, they continued to show rigidity of thinking more characteristic of the pre-operational child when observed carrying out classification tasks.

Observation of General Interview Behavior: In the details of the interviews, the rigidity of thinking described above in all children was exposed by the fact that most judgments had to be elicited. Most of the children tested did not attempt to define the different terms of the tasks spontaneously. The type of judgmental thought had to be suggested by questions repeated over and over in many forms. Ultimately, the questions had to be put in such a way that the subject could simply answer yes or no (e.g., Has the hot dog more clay?). Further-

more, the children almost never tried to justify their answers spontaneously. Among all the tests of the battery, only five out of 57 subjects offered spontaneous explanations for their judgment.

DISCUSSION

We are not entirely without data for comparison. Millie Almy, in a study¹ of lower-class children in the federal housing projects in the same area of New York City as that from which our population was drawn, reported that her test group had developed the capacity for conservation of number and liquids around the age of 8. A group drawn from a middle-class neighborhood in Brooklyn, which she had tested with the same instruments, had developed these capacities a year earlier, at the age of 7. The group of dyssocial children tested in our project did not reach the level of conservational ability until an average age of at least 10. They are, in relative terms, three years behind the middle-class group and two years behind the housing project lower-class group from the same area of the city. This means, of course, that the thought processes of these children remain characteristic of the preoperational egocentric phase of cognitive development for a significantly longer period than in the average child.

We have no similar data to use for comparison purposes with respect to our findings in the various areas of classification operations.

We are convinced, however, that explanations for the developmental lags noted both in conservation and classifications and also for the rigidity of thought are to be found in the family environment.

We are currently working with the families of a large number of the chil-

dren we tested, and hope to be able to collect comprehensive data on the operations of their families over a long enough period of time to enable us to see more clearly what might be the specific causes of the lag in cognitive development observed. So far, we have noted a number of variables that we think are contributory to this lag in a group of cases which we hope to report in a forthcoming paper.

Generally speaking, however, our observations of these families are consistent with clinical observations reported previously by one of the authors and by others, among them S. Minuchin et al.¹⁰ These workers studied the intrafamilial communications of slum families who produced dyssocial children and observed gross deficits in the capacity of these families to organize data, to plan, to make decisions as a group, and to resolve conflict—which seem related to incompletely developed cognitive capacities not only in the labeled children but in all or most members of their families.

The child "acts" classifications long before he "speaks" them. With the advent of the symbolic function he learns to label clusters of objects and experiences. Language provides both a conventionally communicable resource of labels and a relational structure. The lacks of disadvantaged children in both these areas are reported in many studies, such as that of V. John⁹ for example, which have focused on the language of slum children and have revealed the degree to which limited vocabulary and language usage in patterned communication disrupt the operational capacity of these youngsters.

However, Piaget¹² has put together some rather good evidence that, although language and socialization are important

factors in the development of cognitive structures, they are not primary factors. If we remain within Piaget's theoretical frame of reference, equilibration would seem to be the most basic process common to other factors of development such as language, maturation, and socialization. The child, when confronted with variation of his environment will regulate his response in order to adapt to the new conditions. The processes of verbal and nonverbal communication in the families we have observed are not constructed in such a way as to demand such regulatory responses. There is a lack of exchange focused on one topic (various qualifying adjectives have been used to describe this style: discontinuous, topic-switching, interrupted), so that information, alternate hypotheses, contradictions, or choices are not given to the child. The equilibrium of the evolving cognitive schema thus is not challenged, and the process of disequilibrium-regulation-disequilibrium-regulation-etc. which promotes full growth of more complete and stable cognitive structures does not occur.

Many interesting and quite practical issues will be raised if our findings are corroborated by more rigorous study, especially if one focuses on the interface between the child from this group and the expectations of those with whom he deals in various life arenas.

The most obviously troubled transactions outside the home, for example, are those taking place in the arena of school.

School curricula in the U. S., although their development has not been related to what is known about the sequence of cognitive development, have nevertheless been based on the observations of educators as to what kinds of learning

experiences, curriculum content, and materials children were able to cope with at various ages. The frequently described shift to more complicated materials in the third grade, and the greater expectation of autonomy there, make sense when one recognizes that middle-class children and many lower-class children reach the stage of concrete operations between ages 7 and 8. Children such as those we tested, however, will find themselves in serious trouble at this point, since on the average they are still at least two years away from the development of necessary cognitive capacities. Teachers in the classrooms into which these children come have not been trained in the cognitive frame of reference, nor do they have the techniques and skills needed to pinpoint these specific developmental lags. They only recognize that the child has a problem in learning or "is immature." Since these children are not prepared for participation in classroom operations, and since they are action-oriented by virtue of their level of cognitive capacity, they also cannot maintain acceptable classroom behavior. They are therefore disruptive in the classroom, and are rapidly caught in the machinery set up for so-called "disturbed" or "problem" children. Experts are soon called in if they are available, and the labeling process proceeds. Many of these children came to us after having acquired several labels, the content of these labels depending on who had seen them, their particular state of mind at the time of the diagnostic instruments used, and the frame of reference used to determine what diagnostic data to collect and how to order it. Diagnosis is, after all, a social process usually carried out by a middle-class professional trained in a particular discipline who, if he were not

impressed with his diagnostic tools and labels, would not be using them.

We would like to submit, in closing, an approach to the problems of these children that would begin the process of diagnosis and treatment with an assessment of the child's cognitive capacities. If he were found to be developmentally behind the stage necessary for him to cope with his social environment, a remedial curriculum geared to his needs for cognitive growth could be provided. If he still proved unable to assimilate the growth experience, an investigation could be instituted to determine whether his difficulties are to be found in his soma, his emotional psyche, his family, or some external system such as his classroom. The target(s) of therapeutic effort, under such an approach, could be determined with much more clarity.

Even if nothing else were accomplished by following this procedure, we would spare the child the tyranny of being responded to by those around him in a way that tends to make his label a self-fulfilling prophecy. We would also please teachers—who are tired of receiving reports which tell them that their problem pupil has a problem—by providing information that, in a joint effort, can be used to develop curricula for use with these children.

The authors are currently working on elements of such a curriculum with teachers in our district. Our most grandiose hope, of course, is that when developed its use will make our tasks, as mental health professionals, more frequently irrelevant.

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INTELLECTUAL AND PERSONALITY FACTORS IN EFFECTIVE CHILD CARE WORKERS

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Psychological tests were administered to child care workers in a residential treatment center; supervisors rated them on personality traits and job performance. Correlations reveal some predicted and some unanticipated associations between IQ, supervisors' ratings, workers' self-ratings, and findings from projective tests.

Although experienced supervisory personnel in the field seem to possess intuitive feelings about the kinds of individuals who make good child care workers, there are few published objective findings that could be utilized by people responsible for staffing residential treatment centers.

Child care workers, the adults who spend the greatest amount of time with child patients and, therefore, have considerable opportunity to influence the children's daily behavior, usually have the least preparation for their work. The professionals in the treatment setting

come from their respective academic backgrounds, and their titles (e.g., psychologist, caseworker, group worker, teacher, or psychiatrist) convey considerable information about the kinds of experience they have undergone, the basic knowledge they possess, and the duties they are prepared to perform. Although relatively little may be known about the personality attributes related to job performance of these professional members of the treatment team, at least it is known that they have gone through a certain screening process and have successfully jumped the required aca-

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demic hurdles before being allowed to work with disturbed children in the capacity of teacher, physician, or psychotherapist.

In view of the child care worker's crucial role in the treatment process, we have embarked on a program designed to uncover information about the kinds of people who enter this aspect of the orthopsychiatric field. In addition to assessing intelligence and personality in a group of child care workers, this research explores relationships between these personal factors and several indices of the effectiveness with which they perform their work.

PSYCHOLOGICAL ASSESSMENT

The subjects for this study were 34 child care workers hired at the Bradley Hospital between January 1962 and January 1966. The assessment was not utilized for purposes of screening applicants; it was conducted only after people had been hired by the child care administrators. The child care workers were scheduled for individual testing and were informed by the examining clinical psychologist that the findings would be used solely for research purposes and would not affect them personally.

The assessment battery consisted of: (1) two verbal (comprehension and vocabulary) and two performance (picture completion and block designs) subtests from Form I of the Wechsler-Bellevue Intelligence Scale; (2) Rorschach Test; (3) Thematic Apperception Test (TAT) cards 1, 2, 3GF, 4, 7GF, 10, 12F, and 13MF (comparable cards from the male series were used with male subjects); and (4) Davids Self-Rating Scales (completed by 16 of the subjects).

The intelligence testing yielded mea-

sures of Verbal, Performance, and Full Scale IQ. The Rorschach was scored for formal variables, believed to be positive signs, that Davids and Talmadge⁵ have previously found to be predictive of positive movement in psychiatric casework. The TAT was scored for personality traits that have been found to form an "affiliation syndrome" and an "alienation syndrome."²⁻⁴ The traits indicative of affiliation are sociocentricity, optimism, and trust, while those indicative of alienation are egocentricity, pessimism, distrust, anxiety, and resentment. The TAT stories were also scored for negative endings. Self-ratings were made on 4-point scales, on which the subject compared himself with others and assigned a rating of "much less than most people" to "much more than most people." A description of the personality characteristic was provided for each rating to be made and the subject rated himself on the eight traits that form the affiliation and alienation syndromes.

SUPERVISORS' EVALUATIONS OF PERSONALITY AND BEHAVIOR

Following a period of at least several months on the job, the child care director (master's degree in social group work, plus 20 years' experience in this treatment setting) and a line supervisor (college degree, plus 10 years' experience, but no professional training) independently rated each individual in this study on several measures of personality and effectiveness of job performance. The supervisors' personality ratings of the workers were made in regard to the same traits and using the same 4-point scales as those employed on the self-rating scales. Definitions were provided for each trait and, in making the ratings, the rater was instructed to "compare

this worker with other workers you know." In evaluating job performance, the supervisors checked the appropriate category (poor, fair, good, excellent) that best described the worker in regard to each of the following behavioral characteristics.

Factor I was labeled "ability to get along well with others," and consisted of ratings for the following subareas: (1) relations with supervisory personnel, (2) relations with fellow child care workers, and (3) relations with patients. Factor II was labeled "skills and abilities, and on-the-job effectiveness," and consisted of separate ratings for the following areas: (1) skills in recreational activities (e.g., athletics), (2) skills in educational activities (e.g., arts and crafts), (3) discipline and control of children, and (4) ability to understand the children. Factor III was called "parental functions," and consisted of a single rating on ability to serve as parent-substitute for the children (getting them up in the morning, to bed at night, to dress properly, eat properly, maintain cleanliness, and so forth). Factor IV referred to "frustration tolerance" and consisted of a single evaluation of the worker's manner of responding to frustrating experiences, such as things going wrong, upsetting events, and unanticipated interference with plans. Factor V was labeled "potential for growth" and

consisted of a single evaluation of the worker's flexibility and ability to change on the basis of new experience and increased knowledge (e.g., benefit from supervision, inservice training, and daily experiences).

ANALYSIS OF DATA

Correlations were computed to show degree of agreement between the two supervisors' evaluations, and to measure association between their ratings of personality attributes and ratings of job performance. Findings from the psychological assessment were correlated with the supervisors' ratings in order to discover psychological test signs that may be predictive of effectiveness of functioning in the everyday work situation.

RESULTS

TABLE 1 shows age, sex, and IQs of the 34 subjects in this investigation. The findings in regard to intellectual functioning are most impressive, with a mean IQ of 120 and a range of 99 to 145. Many of these child care workers seemed like bright individuals, but we were rather surprised to discover such uniformly high performance on the formal intelligence test. It should be pointed out that no conscious effort had been made to hire only people who possessed above-average intelligence. Since we are aware of no previously published findings show-

Table 1
AGE, SEX, AND IQ OF THE CHILD CARE WORKERS

VARIABLE	MALES (N=11)		FEMALES (N=23)		TOTAL (N=34)	
	Mean	Range	Mean	Range	Mean	Range
Age	24.6	21-32	23.1	18-30	23.5	18-32
Verbal IQ	123.0	114-139	118.7	95-145	120.1	95-145
Perf. IQ	118.4	85-138	116.7	90-144	117.2	85-144
Full Scale IQ	122.4	101-131	119.4	99-145	120.4	99-145

ing relations between IQ and effectiveness of functioning in the capacity of aide, attendant, or child care worker, there was no factual basis on which to purposely screen applicants to obtain only the brightest. The present research program will, however, provide some empirical evidence on which to base future judgments of the importance of high intellect.

In order to obtain a comprehensive picture of relations between IQ and job performance, it will be necessary to conduct similar studies in varied settings, working with differing levels of intellect in the workers being evaluated. It may well be that different associations would be found depending upon the range and mean IQ in the group of workers in the institution. Thus, findings from the present study may be limited to settings very similar to ours and to workers whose intellectual level is above the mean of the general population.

Let us turn now to indices of agreement between the supervisors' evaluations of the workers' personality and behavior. Correlations (r) for their ratings of the workers' standing on the affiliation syndrome and the alienation syndrome are .53 and .56. Correlations for the supervisors' behavioral ratings are as follows: Factor I=.76; Factor II=.79; Factor III=.63; Factor IV=.64; Factor V=.73. When the ratings for the five separate factors are combined to form a global behavior rating, the correlation obtained between the two supervisors' evaluations is .85. All of these coefficients are statistically significant beyond the .01 level.

It is noteworthy that the supervisors agree to a greater degree on their behavior ratings than on their personality

ratings. It seems likely that personality traits, which are determined in large measure by unconscious, covert components, would be more difficult to assess reliably and accurately than would aspects of overt behavior evidenced in performance of one's daily work. However, considering the complexity of the task required in rating several fundamental aspects of behaviors revealed by 34 individuals in their job performance, the correlation of .85 found with the global behavior ratings is of exceptionally high magnitude.

It may be argued that these two members of the supervisory staff possessed much information in common about these individuals, that they had probably discussed them, heard each other's supervisory opinions over the months, and so forth. We would not view this as a valid criticism or as indicative of a methodological flaw. The ratings for purposes of the present study were made independently and with complete unawareness of each other's evaluations. The findings show that these two judges agreed remarkably well in their evaluations of important aspects of personality and behavior in workers under their jurisdiction. These empirical results are in keeping with what we would expect, and hope, to find. But it should be realized that it is perfectly possible to obtain no agreement or even negative associations between evaluations of personality and/or behavior made by observers looking at individuals from different vantage points. In this regard, it would be interesting to see if psychotherapists who work in the setting would agree with the child care supervisors' evaluations, or whether the workers' ratings of one another would be in agreement, or whether

the child psychiatric patients would agree with the supervisors in their judgments of the workers' personality traits and job performance.

TABLE 2 shows correlations between personality ratings and behavioral ratings for each of the two raters. In general, favorable personality evaluations tend to be associated with favorable ratings of job performance, although the degree of association differs somewhat depending upon the aspect of behavior being judged and the rater making the judgment. When the average of the two raters' combined behavioral ratings (which include the five factors) are correlated with the average of their personality ratings, the behavioral rating correlates .71 with affiliation rating and $-.77$ with alienation rating. Thus, the overall pattern is one of significant association between evaluation of personality and job performance. Naturally, these findings can provide no answers about cause and effect, but merely reveal

that these relationships exist in the present study.

Turning now to relations between these evaluations and measures derived from the psychological tests, a most interesting finding is the complete lack of association, according to supervisors' evaluations, between IQ and either personality or job effectiveness. For Rater I, the IQ obtained by the workers on the intelligence test correlates $-.06$ with affiliation rating, $-.18$ with alienation rating, and $-.10$ with combined behavioral rating (five factors). For Rater II, the comparable correlations are $-.03$, $.05$, and $-.08$. According to the judgment of these two experienced supervisors of child care workers, there is no association between IQ as measured by a formal intelligence test and personality traits or job effectiveness. In this regard, however, it must be reemphasized that all findings in this report should be viewed in the light of the above-average intellectual standing of the group being evaluated.

Table 2
CORRELATIONS (r) BETWEEN SUPERVISORS' PERSONALITY RATINGS AND
BEHAVIORAL RATINGS

	RATER I		RATER II	
	Affiliation	Alienation	Affiliation	Alienation
Factor I (social relations)	.81	$-.75$	.41	$-.57$
Factor II (skills and abilities)	.58	$-.53$	.04	$-.13$
Factor III (parental functions)	.42	$-.19$	.25	$-.30$
Factor IV (frustration tolerance)	.61	$-.54$	.37	$-.40$
Factor V (growth potential)	.70	$-.72$	.51	$-.62$

Note: With $N=34$, coefficient of .35 is significant at .05 level and coefficient of .41 is significant at .01 level.

We next attempted to discover relations between the workers' self-ratings and evaluations received from supervisors. Since similar findings were obtained using ratings from either supervisor, for the remainder of this presentation we have utilized only the more experienced supervisor's ratings. Correlations between his ratings and the workers' self-ratings reveal rather surprising negative coefficients of $-.62$ for the affiliation syndrome and $-.66$ for the alienation syndrome. These statistically significant correlations (with $N=16$, r of $.50$ is significant at $.05$ level) indicate that the supervisor rates their personality traits differently than the workers rate themselves. Moreover, the supervisor's global behavior ratings (including the five factors) correlate $-.62$ with the workers' self-ratings on the affiliation syndrome and $.58$ with their alienation self-ratings. Both of these coefficients are statistically significant, indicating that workers who receive more favorable job evaluations tend to rate themselves as higher on alienation traits and lower on affiliation traits.

Several alternative explanations could account for these unexpected findings. They might indicate insight or lack of defensiveness on the workers' part, with those who willingly avow possession of negative personality attributes being

those whom the supervisors find easier to work with. That is, an honesty and lack of defensiveness in self-evaluation might conceivably lead to making a favorable impression on one's supervisors. Or it might be that a certain degree of personal and social maladjustment, as indicated in these personality self-ratings, is desirable for working well with emotionally disturbed children. Or, then again, they may be attributed to some chance factor, especially with such a small sample, but only further research will provide a firm basis on which to interpret such findings. For now we will view them as unexpected, perplexing, thought-provoking, and in need of replication.

We next turned to relations between findings from the projective tests and the supervisor's ratings. As shown in TABLE 3, the Rorschach movement score, which is based on Rorschach signs believed to be indicative of good adjustment, correlates significantly with the affiliation and alienation ratings. The TAT alienation score, which is based on percentage of the story content indicative of traits in the alienation syndrome, also correlates significantly with the supervisor's personality ratings. Another projective measure, based on number of negative endings (unhappy outcomes) on the TAT, shows similar

Table 3
CORRELATIONS (r) BETWEEN SUPERVISOR'S RATINGS AND PROJECTIVE MEASURES

PROJECTIVE MEASURES	SUPERVISOR'S RATINGS		
	Affiliation Syndrome	Alienation Syndrome	Behavior
Rorschach Movement Score	.37	-.45	.19
TAT Alienation Score	-.39	.40	-.27
TAT Negative Endings	-.29	.35	-.24

Note: With $N=34$, coefficient of $.35$ is significant at $.05$ level and coefficient of $.41$ is significant at $.01$ level.

correlations with the personality ratings. Correlations between the supervisor's behavior ratings and the various projective measures of psychodynamics were also in the expected direction but were not significant. Actually, all these coefficients are of low magnitude, and are more suggestive of trends than they are indicative of high degree of association between indices of psychological functioning derived from projective tests and from real-life evaluations.

In this regard, we intend to utilize additional objective assessment methods in our future researches. We have recently included Gough's Adjective Check List and the California Psychological Inventory in our battery of procedures being used in assessment of child care workers. Indices of personality derived from one's self-evaluations and from direct responses to items on an objective personality inventory may well be more predictive of personality attributes and behavioral characteristics shown in the everyday job situation than are scores derived from responses to projective stimuli. While use of projective tests may not result in highly significant statistical findings for groups of subjects, analysis of Rorschach percepts, TAT fantasies, and unconscious material revealed by other projective techniques may be extremely valuable in attempting to formulate a comprehensive understanding of the psychodynamics of an individual case. Thus, we would advocate the use of projective tests for purposes of case studies and for studying relations between personality attributes revealed at different levels of consciousness, but we also think it essential to include objective methods in our future attempts to study personality and job performance in groups of normal people.

DISCUSSION AND CONCLUSIONS

Psychological assessments of child care workers can contribute to evaluation of inservice educational programs. New personnel could be assessed, prior to and following a period of inservice training, to discover any positive changes resulting from attendance at lectures, participation in seminars, and/or supervised work experiences during the training period. It would also be worthwhile to assess child care workers at various stages in their employment, thereby revealing any desirable or undesirable changes in personality, motivation, or behavior accompanying increased experience on the job.

Another facet of this type of research would be to study reasons for terminating employment. In preparing the present report, we discovered that of the original group of 34 individuals studied, only nine were still working in this situation. There are many "good" reasons for terminating employment (e.g., marriage, pregnancy, military service, returning to school, obtaining better position in related type of work) but there are also many undesirable reasons (e.g., dismissal, quitting in anger or disgust, finding the work too emotionally upsetting). Future research should attempt to discover signs from the psychological assessment that predict the conditions under which the person later terminates as child care worker.

Closely related is the question of the influence this work experience has on the person's later career. Many child care workers continue their formal education during their employment and/or go on to further education after leaving this position. Some eventually obtain advanced degrees, and we happily discover years later that they have become

teachers in special education, psychiatric social workers, social group workers, psychologists, or physicians. It may well be that the eventual reasons for terminating employment are determined prior to the actual work experience, and that whether or not the person eventually pursues a professional career in a related field is also independent of the clinical work experience. It would, however, be worthwhile to investigate motivational effects on the individual of having worked in the residential treatment setting, interacting daily with disturbed children and with members of the orthopsychiatric team.

Certain new developments in the field of orthopsychiatry might benefit from studies extending the present research. There has recently been increased interest in the negative and positive features of group placement for young children, with some questioning of conclusions drawn on the basis of early studies of effects of childhood institutionalization on later adjustment. Consideration is now being given to possible advantages of certain kinds of group living over the unhealthy family living experienced by many children. If greater future use is to be made of group placement for children, it will be essential to gain increased knowledge about the kinds of people who are best suited for working with children in institutions.

We should also consider training parents to better understand their disturbed children and to acquire effective methods for coping with their deviant behavior. If inexperienced people can be educated to become good parental substitutes, why can we not teach parents to respond to their own disturbed children in keeping with principles and practices employed in the residential treatment set-

ting? If such training programs were instituted, it would seem invaluable to conduct psychological assessments of the parents at the onset of the program and again at some later date following the educational experience.

There is currently much emphasis on the use of nonprofessionals as active workers in the field of mental health. High school graduates (or even "drop-outs"), college graduates, housewives, and other categories of nonprofessionally trained people are being used in exploratory programs as social work assistants, as psychological examiners, and as therapists. These people work under the close supervision of highly educated, fully qualified, experts in their fields but carry out much of the actual work with the clients or patients themselves. Only a few years ago such happenings would have been unthinkable and unacceptable.

In this regard, Truax⁶ has reviewed a large number of research studies indicating that "when counselors and therapists communicate at a high level of accurate empathic understanding, non-possessive warmth, and genuineness to their human clients, there is consequent patient improvement." Conversely, when they communicate at low levels of empathy, warmth, and genuineness, there is consequent patient deterioration. These findings have been obtained with such diverse populations as hospitalized schizophrenics, neurotic outpatients, college underachievers, and juvenile delinquents. Further evidence cited by Truax suggests that these interpersonal qualities lead to positive consequences not only in treatment conducted by professionally trained psychotherapists but also in studies of parental effects upon children, teacher effects upon personality

development of their pupils, and even in laboratory studies of learning and behavior change.

Most important for our present purposes is the attempt by Truax and his collaborators to translate these research findings into effective training programs for both professional and nonprofessional personnel. Using attendants and volunteer workers in a state hospital, Truax found that "nonprofessional hospital personnel could indeed be trained to provide effective therapeutic conditions for severely disturbed patient populations."⁶

Related to these modifications of conventional psychotherapeutic procedure is the recent interest in behavioral therapy as a method of treating varied types of psychopathology. There are reports¹ of successful outcomes of behavioral therapy programs conducted by parents in the home and by attendants in institutions. While the treatment programs are designed and supervised by professional behavioral scientists, the "therapy" (behavioral change) occurs through the efforts of the adult who serves as reinforcing agent, and there is

likely to be increasing use of nonprofessionals in the role of behavior modifier or social reinforcer. In view of these varied but interrelated developments, it seems highly important to conduct psychological studies of factors to be used in the selection and training of lay people with good potential for becoming effective mental health workers.

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CLINICAL

A PSYCHIATRIC UNIT IN A GENERAL HOSPITAL PEDIATRIC CLINIC

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Emerging concepts of community mental health care suggest the need to revise the traditional orientation of child guidance centers. This paper describes new approaches embodied in the psychiatric unit of Bellevue Hospital's pediatric outpatient department. Based on interdisciplinary teamwork, the changes facilitate quick evaluation and flexible work-up and treatment programs.

Much attention has been paid in recent years to the concept of community mental health care. The idea first arose early in the century as a result of Healy's pioneering work with delinquent children. From his experience in a community clinic there developed a team approach to the treatment of disturbed children. The first child guidance clinics in this country were opened in 1922, and their number rapidly multiplied.

Although the need for such diagnostic and treatment centers is undeniable, cer-

tain questions have lately been raised about their approach and functioning. The first question involves their physical location. Usually the clinics are self-contained units scattered throughout urban districts, to which children are referred by outside agencies and individuals. While this procedure permits the clinics to draw patients from a wide area, it has a drawback. The isolation of the clinics from other community medical resources prevents close interdisciplinary cooperation and limits the

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comprehensive care of a child. For this reason, when the pediatric outpatient department at Bellevue Hospital in New York City asked us to develop a program of psychiatric coverage for their unit, we decided that the place to do our work was within the outpatient department itself.

The philosophy of comprehensive care emphasizes the importance of obtaining coordinated medical work-ups of a child within the same geographic area. Since other medical specialty groups were also setting up their clinics in the Bellevue pediatric outpatient area, we foresaw the advantages of close liaison between the various services concerned with the child. The fact that we were not in a separate building or institution would give us the opportunity to develop good working relationships with pediatricians, other specialists, and nurses. We could orient them to psychological issues and expedite necessary work-ups. When a psychiatric problem arose, we could be called on quickly for help.

Once this decision was made, we departed still further from the model of the conventional child guidance clinic. When a child is referred to such a clinic, he goes through a complicated "intake" process. First, he is placed on a waiting list, on which he may remain for as long as a year. When the child's turn for evaluation comes, a social worker interviews the parents, a psychologist does a full battery of tests, and a psychiatrist conducts a clinical examination. The child's pediatric status is obtained from a hospital or private physician, or, at times, from a pediatrician who works at the clinic and does routine physicals.

Then a conference is held to evaluate the data and decide upon the therapeutic approach. In most cases, the recommendation is psychotherapy for the child and visits with a social worker for the mother. Again, the child is put on a waiting list, this time until a psychiatrist can find an opening for him.

This standard approach appeared to be undesirable for our clinic for several reasons: (1) The long waiting lists make it impossible to give a child immediate attention at the time of referral. (2) It is wasteful to do an elaborate work-up in every case. (3) If every patient gets the same recommendations for therapy, why bother with the initial work-up at all? (4) The same treatment should not be recommended in every case.

We therefore adopted a different approach. Basically, our approach involves seeing a child immediately when a consultation is requested, obtaining a quick diagnostic judgment, arranging promptly for further work-ups that seem required by the specific case, and planning an individualized treatment program.* In this paper we will discuss the rationale for this approach, the special problems it raises, and our specific experience with it.

IMMEDIATE DIAGNOSIS

In the past decade, many attempts to eliminate clinic waiting lists have been reported. These include: early screening out of cases deemed inappropriate for treatment; prompt handling of crisis situations; group interviews.³ Varying degrees of success have been recorded, but underlying all the programs has been the

* A similar approach has been used at the Yale Child Study Center for emergency cases.⁵ Our program is not limited in this way and handles the general emotional problems of children as well as acute crises.

assumption that a long waiting period between complaint and the diagnostic work-up is antithetical to medical practice in general and psychiatry in particular. It would be absurd for a child complaining of a cough to be placed on a pediatrician's waiting list to be worked up six months later, but it is still all too common for a child with a behavioral complaint to be handled in this way.

Although some psychiatrists^{2, 4} report that as many children improve during the waiting period as in the course of treatment, that is not a valid medical reason for delay. If one failed to give active care to a heterogeneous group of children whose chief complaint was coughing, a follow-up several months later would probably show that a high percentage of the children were improved. This would merely confirm that some medical illnesses are self-limited. It would not absolve the physician of his responsibility to differentiate between those children whose disease is self-limited and those requiring treatment. In either event, he would be expected to propose therapy to speed the cure or minimize the probability of complications.

In child psychiatry, too, one must identify those children who do not need treatment, those who do, and the kind of treatment required. It may take as much effort to identify those who are normal as to spot those who have serious problems requiring care. In fact, it may even be easier to diagnose autism or retardation in a three-year-old who has difficulty with his language development than to establish that he is normal but displaying a specific developmental lag.

The clinic's responsibility is to facilitate an immediate diagnosis in order to determine if intervention is necessary

and, if so, what is appropriate in the specific case. In our clinic, therefore, as soon as a consultation is requested, one of the six members of the professional psychiatric team (two psychiatrists, two psychologists, and two psychiatric social workers) sees the child and his parents. The six staff members alternate their assignments so that there is someone on call from 9 to 5 every day to screen referrals. In addition, the unit includes a part-time remedial teacher and, a most crucial member, an administrative coordinator.

The consultation is initiated either by a pediatrician, a physician in one of the other specialty clinics, the social service department, a school, or a community agency. Usually, when the child is in the pediatric clinic either for the treatment of an acute illness, a routine follow-up for some chronic illness that is under control, or a well-child checkup, the pediatrician himself notes something unusual or the parents mention troublesome behavioral problems. The pediatrician then fills out a referral form, which includes the following questions:

REFERRAL FORM

Reason for referral:

Describe behavior observed:

Describe behavior as reported by:

(informant)

- (1) At home:
- (2) At school:
- (3) Appropriate to age?
- (4) Clinical estimate of intelligence:

Medical status:

- (1) Current medical problems:
 - (2) Relevant medical history:
 - (3) Medical problems now under investigation:
 - (4) Long-term medication being employed:
-

Within 15 minutes to an hour after the referral form is received, a member of the psychiatric unit conducts a screening interview with the child and his mother (or other adult who has brought him to the clinic). The behavioral complaints are obtained, as well as information about his school placement and other pertinent social data. In addition, the child is observed. If the situation warrants it, other members of the team are consulted. For example, if a psychiatrist doing the screening feels that there is a question about whether the child is mentally retarded, and if an immediate answer is necessary for the proper dispensation of the case, he may call in a psychologist to administer a brief sample test. Even if this gives only vague clues to the child's mental status, it will disclose whether he is testable at all, and thus indicate the worth of planning further examinations. A social worker may call in a psychiatrist if the mother appears disorganized and an appraisal of her ability to understand the situation is required. A consultation with the psychiatrist in charge of admissions to the child psychiatry ward may be necessary if the child appears to need emergency hospitalization.

In many cases, the patient can be evaluated on the basis of the screening interview alone. In other cases, it may be decided that further diagnosis is required and whatever seems appropriate to the specific situation will be arranged for—neurological examination, psychological test, etc. Not all the children get the same work-up. Rather, they all are initially screened, and only then is it decided what further work will be pertinent.

We have found that, with careful

training, each member of the team can do a competent screening interview no matter what his specialty background. An experienced social worker or psychologist can be taught to garner the essential information in the initial evaluation without the help of a psychiatrist. The clinic director is available daily to review the referred cases.

The screening interview differs from the traditional clinic intake interview in which a social worker focuses on the parents and their attitudes but commonly neglects such factors as the patient's physical health and details of his antenatal and neonatal history. Since the conventional clinics usually assume that a complaint is sufficient evidence that a psychiatric problem does, in fact, exist, they automatically require a full work-up of each child.

In contrast, our decision about the extent and intensity of the work-up required is determined by the nature of the individual case. The goal of the work-up is to establish a diagnosis and define a plan of management. The amount of social and environmental investigation will vary, depending upon the case. The need for psychological testing also depends on the individual case. Rather than use a psychologist's time for unnecessary procedures, we prefer to budget it for those cases in which a definite psychological question has been raised. Thus, if no pathology is reported in the school situation and clinical impressions of the child's intelligence indicate that he is of average or above average intelligence, formal testing may not be deemed pertinent. However, if there is a psychological question, such as a definition of the child's intellectual capacity and identification of defective cognitive ability, some testing may

be required. In other instances, the first psychological examination may itself point to the need for detailed testing to assess such specific capacities as the child's perceptual integrity. In no case is any test or battery of tests routinely recommended.

In addition to the social and psychological work-ups, information from other medical clinics may be needed to make the psychiatric diagnosis. On the basis of the pediatric history and observation of the child, it may become apparent that there are questions about his coordination, visual intactness, or general state of health that require further investigation. In such cases, the appropriate referrals will then be made to the other clinics (e.g., neurology, orthopedics, cardiac, speech and hearing).

In the outpatient department there are two staffed playrooms, one for toddlers and one for children over five years of age, used for patients or their sibs awaiting pediatric appointments. We frequently have planned observations of referred children as part of our diagnostic procedure. The recreation workers supply detailed reports of the child's activities and relationships in one or more playroom sessions.

Although the presence of our unit within the pediatric clinic of a general hospital facilitates these referrals (physically, we are almost automatically part of the team), the very nature of the hospital set-up can also work against us. Routine functioning in such an institution involves making the appropriate referrals, waiting for the reports to be returned, and then taking further action in accordance with the findings of the specialty clinic. And, as things work in a busy hospital, there are many points at which such a procedure may fail to

pursue the patient's best interests, let alone our goal of immediate and specific response to a problem.

For this reason, we have assumed the responsibility of extensive communication both with those who have referred patients to us and those to whom we refer patients for consultation. A copy of our diagnostic work-up is sent directly to the referring pediatrician, who is kept informed of the child's progress in our unit. In addition, we directly contact those to whom the patient is sent to make sure that they are aware of the specific questions we are asking, that the patient keeps his appointment, and that we are informed of the results of the consultation.

To expedite this intercommunication, we have an administrative coordinator whose job it is to secure the necessary reports, to make appointments, and to follow the patients through some of the existing red tape. We have found that unless there is one person to check on the progress of the various work-ups and to keep data moving between clinics, a case can easily get lost and our basic plan of immediate response to the child's needs can become side-tracked.

Since the speed with which a case can be handled depends on the general habits that prevail in other services, we distinguish between cases in which the requested information is central to psychiatric management and those in which it is useful but not decisive. In the former situation, we have made some special arrangements for earlier processing of referrals from the psychiatric unit. In the latter, the children are examined in turn and therapy is begun while we await the consultant's report.

In sum, during these preliminary stages we have assumed the traditional

role of the family physician in correlating the various aspects of the child's health care. We collect the data, inform the parents when the child's functioning is normal, and discuss the origin and nature of a disability when a behavioral aberration is found. Instead of finding fault with record rooms, delinquent parents, and aides who lose charts, we assume responsibility for correlating clinic services, recognizing that this is one of the special problems of this kind of unit.

The team members must function in roles unlike those they play in traditional clinics. In screening, they must secure information on all aspects of the child's functioning. In doing follow-ups, we have avoided the traditional situation in which the social worker is the only person to communicate with the outside. If a question arises about the child's reading ability during the course of psychological testing, the psychologist will himself call the school for whatever additional information he needs himself. In other cases, too, the person with a question follows through to get the answer.

Working within an outpatient pediatric setting has highlighted for us the very important issues involved in the selection of a therapeutic modality. In medicine, more refined knowledge about etiology and prognosis has led to therapeutic programs of increased selectivity and specificity. Treatment may range from bed rest through open heart surgery, from a dietary regimen to peritoneal dialysis. In psychiatry, too, it is necessary to make selective use of a wide armamentarium of therapeutic procedures.

It is often said that the diagnostic procedures used in many child guidance clinics have little value because the same

decision is always made—individual casework for the parents, individual or group psychotherapy for the child, both on a long-term basis. The same objection should be made to the employment of the same therapy for all cases. A time-consuming treatment, if incorrectly selected, means not only that one has failed to provide the best treatment for a given case but that time has not been available for treating other cases.

These issues are particularly relevant if a child psychiatry unit is set up predominantly to conduct individual psychotherapy, as most guidance clinics are; the first group of cases accepted will occupy all the time available, precluding attention to other cases. Since the results of individual psychotherapy are not more impressive than those of less costly and time-consuming procedures,¹ concentrating on this approach has not helped psychiatry fulfill its responsibility to the waiting children.

We have not taken an all-or-nothing approach to treatment. Instead, we recommend a variety of approaches, each of which is used when it seems pertinent to the needs of the individual patient. In our unit, the following approaches have been used:

1. A single informing interview with the parent and later follow-up contact by either a member of the psychiatric unit or the referring pediatrician. In this interview, the parents are informed of the essential normalcy of the child's behavior and are given reassurance that it should not be a source of concern. Interpretations of the youngster's functioning are offered, with suggestions about how to minimize the annoying repercussions of his behavior.

2. An informing interview with the parents and consultation with other environmental agencies concerned with the child, to discuss our reasons for considering him normal and to offer advice for handling him optimally.
3. Parent guidance. This is recommended when the child has a reactive behavior disorder and parental handling is not consistent with the child's healthiest development. The parents are seen for a varying number of sessions by a psychiatrist, social worker, or psychologist. Their day-to-day handling of the child is discussed, and they are given advice about how best to structure their functioning so as to alter their offspring's habitual behavior and attitudes. Guidance is carried out in the language with which the parents are most familiar.
4. Environmental manipulation. In this approach, the major therapeutic effort is focused on modifying the stressful and dissonant circumstances that seem to be of etiological significance in the child's malfunctioning. This may involve altering his school placement, arranging recreational opportunities, having the parents give him a bed of his own, etc.
5. Group discussions with parents, child, or both. These may be handled as milieu therapy, activity groups, or a combination of the two. Children selected for a group may be those with a common illness. For example, one group of diabetic children came into being when the clinic nurses continued asking for consultations about how to handle the similar problems these youngsters had. Parents who are having similar management problems also may be placed in groups for discussion. These are not therapeutic groups per se; if the parents, themselves, require treatment, they are referred to the mental hygiene clinic.
6. Remedial education. Children whose emotional problems have created secondary learning difficulties may be recommended for such treatment. As a result of his behavior difficulties, a child may be able to learn only in a one-to-one situation with a teacher who takes into consideration his particular sensitivities, demoralization, and emotional blocks. Children whose learning problems stem from developmental reading and arithmetic lags or perceptual difficulties may also need a period of individual remedial work to bring them to the point where they can be placed in their school's general remedial program. And, if these children have also developed secondary behavior problems, such as clowning, avoidance, or aggressive behavior, it may be that a therapeutically-oriented period of remedial education will be the treatment of choice.
7. Individual psychotherapy. Some children have problems that are best resolved through the establishment of an individual relationship with a psychiatrist. For example, a child who has had a serious change in behavior following a traumatic episode would probably be best treated by a course of psychotherapy. Children with neurotic patterns of behavior may require an interpretation of their attitudes as being inappropriate for their own aims and interests. If individual work reveals that the child's problems arise in terms of his peer relations, he may be switched to a group. Often, too, the parents may be scheduled for guidance sessions. As with all the other approaches discussed, therapy

may be combined with another treatment modality or the child may be changed from one to another depending on his progress. Our intent is to be flexible and use whatever therapeutic mode seems most appropriate at any stage in every case.

8. Medication. In some cases, such as when a child's hyperactivity has become the nucleus of a negative child-environment interaction, appropriate medication to decrease his activity and increase his attention span may be the sole therapy necessary to initiate a benign child-environment interaction. In other cases, medication aimed at a specific symptom may be combined with one or more of the other therapeutic approaches. If an organic problem is discovered during the psychiatric examination, the child is sent to the appropriate specialty clinic for treatment.

Our psychiatric unit opened in January 1967. During the first year there were 228 referrals to the service. Of these, a majority came from the pediatric general clinic (128). Other referrals came from the various specialty clinics, particularly neurology, the social service department, schools and community agencies, and pediatric inpatient services. All of these youngsters are registered in the pediatric outpatient clinic, which sees an estimated 20,000 child patients a year. Thus we saw approximately 1% of all outpatient pediatric patients. As of the end of December 1967, there were 162 children active with our group.

Needless to say, the type of unit we have established need not be limited to a pediatric clinic, although its location there has certain advantages. What is

crucial, however, is that the goals we have developed be considered in the establishment of other child psychiatry units because our approach—immediate response, quick evaluation, flexible work-ups and treatment programs—are directly applicable to them. These basically, are the goals of other medical specialties and they should also be the aims of child psychiatrists.

To sum up, emerging concepts of community mental health care suggest the need for revising the traditional approaches embodied in most child guidance centers. A number of revisions have been developed for the psychiatric unit of the comprehensive medical care program of the Bellevue Hospital pediatric outpatient department. These have included: (1) Immediate response, within minutes, is made by either a psychiatrist, psychologist, or psychiatric social worker to a request by the pediatric staff for psychiatric evaluation. The usual intake procedure has been abandoned in favor of an immediate screening procedure sufficient to determine whether or not a psychiatric problem exists, and, if so, whether any emergency measure or a scheduled work-up is indicated. (2) Scheduled work-ups are structured for each case so as to establish a diagnosis and define a plan of management. No routine work-up is used for all cases, but rather a schedule of procedures is determined for each case individually. (3) Treatment is considered to include parent guidance, other environmental manipulation, recreational play group activity, and educational remediation, as well as individual or group psychotherapy for child or parent. Formal psychotherapy has been found necessary in only a minority of cases. (4) Active

communication is maintained by all members of the psychiatric team with pediatrician, nurses, pediatric social workers, and recreational workers regarding all children referred to the psychiatric unit.

The above program has involved radical modifications in the usual professional roles of psychiatrist, psychologists, and social workers, as practiced in traditional child guidance centers.

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ENDURING EFFECTS OF VIDEOTAPE PLAYBACK EXPERIENCE ON FAMILY AND MARITAL RELATIONSHIPS

Ian Alger, M.D. and Peter Hogan, M.D.

The playback of videotape recordings made during a therapy session provides a new therapeutic tool. Participants begin to grasp better the context and complexities of human interactions. Sharing this data with therapists leads patients to a more democratic therapeutic interaction, with implications for more democratic functioning in the families themselves.

Videotape equipment has opened exciting new possibilities in therapy, teaching, and research. The importance of the immediate playback and its effect in therapy have been described by several workers including Moore,⁷ Cornelison,⁴ Kagan,⁶ and the present authors.^{1, 5} The fact that so much objective data on the tapes themselves is available for review again and again has application not only in the therapy itself but also in the area of research.

Assessing change in behavior has always been most difficult, but the comparison of television recordings of couples and families over a period of time

provides a new dimension in measurement. No one can be present in a situation and perceive, much less remember, all the complexities of behavior. Comparison of therapists' dictated notes on a session to the television recording of the same session reveals the limits and personal bias in one person's observation and recall. Patients, too, are unaware of much of the interaction in a session, and also of much of the change which may be occurring over a period of time. Comparison by them of serial videorecordings provides convincing evidence that change has occurred.

In this paper, the authors will describe

This paper and the two discussions of it that follow were presented together at the 1968 annual meeting of the American Orthopsychiatric Association, Chicago, Illinois.

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some of the clinical effects of the use of videotape playback in family and marital therapy, focusing particularly on the long-term or enduring influence of the experience. In terms of research these observations are presented as clinical material only, but the way has been opened for a thorough research project into the measurement through videorecordings of change in behavior. In many centers such work is now in progress.

In addition to facilitating a measurement of behavioral change, videorecording also contributes to an understanding of the nature of human behavior. Therapy with natural groups, such as families and couples, is evidence of growing acceptance of the concept that no individual can be understood in isolation. The videorecording is a superb technique for capturing the context of a situation as well as the multiplicity of cueing and other communicational behavior. Insight therapy traditionally was considered to a large degree a "verbal" therapy; the idea of "acting out" was discouraged. But the consideration of behavior in terms of an interpersonal field led to a broadened understanding, and developments in communication theory such as the double-bind² concept also increased the basis of our understanding. Kinesics,³ a study of communication through body movement and gesture, adds further richness to our understanding. The videorecording makes it possible for those involved in a situation to suddenly stand back and observe themselves in the midst of an interactional situation. No longer will a particular experience occur only once; now it can be repeated as often as desired, and over any period of time. One of our patients aptly described the method as a "time-mirror."

There is a marked difference between viewing one's behavior on videotape and viewing it in an actual mirror. First, with videotape there is a virtual image and not a mirror image. But perhaps of greater importance is the possibility of more completely separating the observing-self from the participating-self. In mirror observation, you still have immediate control over the movement of your body in the mirror image, but with videorecording the observing person can only observe and cannot any longer influence the behavior he is watching himself perform. It is essentially because of this phenomenon that a patient is able to become an equal partner with the therapist in the observing and research function of therapy. The effect of this is the development in the patients of a greater sense of personal involvement. When a person observes something for himself rather than having it "pointed-out" to him, he more readily integrates his new awareness without the feeling of being "directed" to do so by someone else.

EQUIPMENT

The actual equipment used will be described briefly. Since less expensive equipment became available in 1965, there has been a continuing development in the field. Refinements and innovations appear with increased frequency. Therefore, anyone wishing to purchase or lease equipment should have a survey made of his particular requirements so that the best current videorecording equipment suited to his specific needs can be obtained.

The essential elements are a video-recorder, a camera, suitable lenses, and proper lighting and seating arrangements. All the equipment can be con-

cealed behind a one-way mirror, or the camera alone can be concealed behind a heavy-mesh cloth so that focal point is behind the cloth. In our method, most of the equipment and the camera are not concealed by deliberate design. It is felt that the procedure is not distracting, and the openness supports one of our therapeutic goals in attempting to integrate therapy with the rest of a person's life.

The camera and recorder can be operated by remote controls if desired. The therapist can do this himself, or an operator at another location can monitor the action and control the cameras. In our work, we either have the camera in fixed-focus for a married couple or have a camera operator present. At times, members of the family have been asked to operate the camera. This has often produced a dual result. First, the family member may reveal a great deal about his own feelings in the way he chooses his scenes. Second, he tends to develop a different perspective on the total situation when he is in place behind the camera. Several patients have commented that they realized after the experience of operating the camera they had found a new perspective in the way they were looking at any situation in which they were later involved.

When a wide-angled lens is used, one can observe the interrelatedness of each participant's behavior. This is especially valuable in determining family interaction and in highlighting established family patterns and covert agreements. A zoom lens is valuable for focusing on a person's facial expression, and such a picture often has great impact. Special effects can be obtained through the use of generators, allowing the use of split-screen images. In this way, two people confronting each other can be placed

side by side on the viewing screen. In more elaborate installations, several cameras can be used to good advantage to obtain shots from different angles. In such a situation, an operator is usually placed in a position at a monitor console to choose the shots to be recorded.

METHOD OF USE

So much for discussion of the actual equipment. The method of use can be varied. In one of our usual sessions, a videorecording is made of the first 10 or 15 minutes of a regular session. The recording is then played back to all participants, with the instruction that anyone can ask that the tape be stopped at any point in the replay. Therapists as well as patients may stop the tape to comment on anyone's behavior or on their own reactions, either as they appear on the recording or as they remember feeling them at the time of the actual session. Patients may be most likely to pick up discrepancies between their observed behavior and their remembered feelings. The therapist may more likely be able to comment on complex patterns of interaction and the cueing and following behavior.

A second way to use the recording is to have the camera operating throughout a regular session with the understanding that at any point anyone may ask that the recording be stopped and the particular section just recorded be played back. This allows an immediate and ready way to check an observation or to review an action that one person observed but another family member missed.

A third method is to record a session entirely, or in large part, and then replay it in its entirety with no stops in order

to allow the impact of the complete unfolding of the interaction.

All these methods can be used in an immediate session, or the videorecordings of one session can be played back at a later session. For example, some of the clinical excerpts used in this paper came from a session in which a married couple viewed the recording of their initial joint therapy session which had occurred over a year earlier.

It is clear that the videorecording is actually a technique, or tool, which has impact in its own right but which lends itself as an adjunct to many styles of therapy. The way in which this technique is used, therefore, will vary greatly with each therapist's style and conceptualization and practice of psychotherapy.

LONG-RANGE EFFECTS

In other papers,^{1, 5} the authors have discussed some of the immediate or short-range effects of the videotape playback experience. One such effect is "image-impact," which has been used by us to describe a person's reaction to the initial viewing of his own image. Another short-range effect is the "second-chance phenomenon": When, on playback, a person becomes aware of a feeling he was experiencing during the original episode, he then has a second chance to communicate this feeling to the others present in a more direct way. The "après vu phenomenon" has a similar basis. On replay, one may become aware of behavior in another person which was not seen earlier. He then has a new opportunity with this "after-view" to react to that person in light of the new awareness.

The long-range, or enduring, effects of the playback experience have two

aspects. The first concerns the effectiveness of playback with repeated use over a period of time. The second has to do with the residual effects of a single or closely connected series of exposures after a longer interval.

The first aspect involves adaptation to confrontation. It is common experience that when playback is used to help someone learn new maneuvers in sports, for example, there is a gradual lessening of the effect after two to three weeks of daily exposure. In other words, the viewer tends to become used to his image in that situation, and so the freshness of the observer-role is diminished. One, in a sense, becomes functionally "blind" to one's own image. Undoubtedly, there is some of this pattern when the playback is used in a therapy situation. Certainly, observation reveals that one becomes less sensitive to one's actual physical appearance. However, even after many months of use patients still find new impact on viewing themselves. One explanation of this may be that the behavior is constantly changing (in a way that is different than when a person is continually practicing a special figure in ice-skating); that is, the behavior is changing in reference to the current set and context, and to the altering ways that other people in the situation are behaving. Thus, although a pattern in one individual may be repetitive in one sense, it also is related to different cues at different times, and the total experience continues to have a freshness which counters mechanical adaptation in the personal response. The further implication of this is that a person viewing himself on different days in different contexts will see that his behavior can be extremely varied. Not only do family members become aware

of this wide range of possible behavior, but therapists too may be startled (and possibly encouraged) to realize that they behave in very different ways at different times and with different patients. An awareness is developed that we are not just static personalities that can be labeled but rather very responsive and adaptive human beings with a wide repertoire of responses and reactions.

One couple we treated viewed their original session about a year and a half later. Many of their comments about the original session were the same as they had been at the time of the immediate playback during the original session, but there was now even greater emotional reaction to some of the original behavior they felt they no longer exhibited to the same degree. The discrepancy between the inner feelings and the behavior which apparently belied the presence of those feelings seemed even more apparent on the new viewing. In this session, the recognition of covert anger was especially emphasized by both husband and wife; and they both commented on the marked change which had occurred during the interim in their capacity to be more in touch with their angry feelings and to express the anger more directly. This same re-viewing experience confirmed a finding of Nielsen.⁸ He found that re-confrontation induced in the couple many of the feelings from the original episode, and that with the new viewing these feelings were now seen in wider perspective and with more acceptance. It has not been our experience that the counterevaluation described by Nielsen is frequently found. He stated that on review several months after an original filming a person would have a different evaluative reaction than he originally had. We found,

in our examples, that the initial reaction was more strongly affirmed on the new viewing.

Repetitive use of the playback method has the effect of increasing sensitivity to a family communication pattern. In one family, for example, the husband began to relate his feeling of frustration when he tried to discipline his son. Almost before he was started, his wife interrupted and began to elaborate and modify the description. As this happened, the husband shifted position several times, turned his head away from his wife, and stared up towards the ceiling. When this pattern was noted on the replay, he became aware of angry feelings and, at the same time, thought that he should listen to his wife. In turn, the wife reported that she felt anxious when he began to talk about difficulties with their son and wanted to make sure that the son's side was fairly presented. As soon as the husband turned away, she realized, she had more anxiety and consequently tried to reduce this by talking more, which only caused further withdrawal on his part. Once this pattern was identified several times, the cycle became interrupted as soon as one partner mentioned the "anxiety cycle." Eventually, the husband became very alert to his shift of position and would immediately identify the now familiar communication pattern. Both were then able to communicate more directly about their anxieties, and clarification resulted. Thus, repeated viewing of playback permits sensitization to a communication pattern, and eventually all that is needed is a slight cue to make one of the family members open up the communication by saying something like, "Here we are at the same old game again!"

CASE EXAMPLES

The residual effects from playback can be very profound, even from a single experience. Image impact often has not only an immediate marked effect but a sustained effect. After a single viewing, one married woman kept referring to her "chicken-pox voice" and to "that frozen puss!" Up to six months later, she would frequently make appropriate references to these qualities, and use them in a metaphorical way to describe a pattern of relating to which she was now quite sensitively aware. The "chicken-pox voice" referred to a tone of arrogant belligerence she had detected when she once asked the therapist what chicken-pox looked like.

One patient continues to refer to an image of himself from a videotape playback session approximately six months earlier. During the actual therapy session, the wife referred to the husband's detachment, his emotional lack of connection, and his unwillingness to struggle with these factors in his relationship with her. This husband accepted, as he usually did, his wife's definition of his behavior—until he watched the playback segment. At that point he realized that while he was somewhat detached he was struggling to make contact, and could respect himself for it. During the playback his wife was also able to see this effort. He has since frequently recalled that image of himself as he saw it on the TV screen to help sustain his self-esteem, and to confirm his genuine effort in responding to his wife.

Another example which was quite dramatic continues to figure in the ongoing relationship of another husband and wife. The husband saw himself for the first time as cringing and servile before his wife, although he had been told

about this behavior many times in individual therapy sessions. As he watched the screen, his reaction was so intense that sweat stood out on his forehead. He said that he couldn't stand to watch it again. He did, however, watch several more times, and then determined to stand up to his wife regardless of the consequences. Since then he has been able to persist in this determination, with the result that a more respectful relationship between them continues to develop.

Therapists also can experience a lasting effect from a vivid realization of their own behavior during videotape playback. Dr. Hogan recalls, and still associates frequently, to the image of himself having an angry exchange with a patient. Following the actual session, he recapitulated in a two-hour period most of the work he had done in his personal analysis concerning his anxiety about uncontrolled anger. More important, while he had become fairly comfortable with his own expression of anger, he realized through seeing this image how people could experience him in a more menacing and threatening way than he himself had been aware. In another videotape session, Dr. Alger on replay saw himself frozen and paralyzed during the interview, even though at the time he had subjectively experienced himself as listening in an interested way. Since that realization, whenever he finds himself frozen in the position of an "interested" listener, he is reminded of that video image and actively moves to alter the situation.

A startling series of moves in one videotaped segment of a joint marital therapy session had profound and lasting effect on the relationship. The husband had begun to discuss his feelings

about a situation in the home when the wife interjected by asking if she could question something. The husband suddenly looked dazed as the wife continued her interruption. As if in a trance, the husband began to follow every physical move the wife made as she moved forward in her chair, then back, then slightly forward and back again. As this sequence was played and replayed on the videotape, the husband became more and more aware of how much he let himself be "taken over" by his wife's directions, so that he was following her in almost automated puppet style. The shocking image of himself rocking back and forth in resonance with her cues stayed with him; and from that time on he was increasingly able to protect himself from this kind of dependent resignation. After a full year the impact of that scene is still powerful, and is still being used by him.

A husband and wife who had been seen separately and in joint session were seen as a family with their two sons. On replay, it became immediately evident that the father and the two sons were in almost constant rapport. Their physical movements coincided and posturing was imitated among the three of them, while the mother appeared to be very isolated in the family group. On viewing this videotape playback, the father became more aware than ever before of his wife's exclusion, and he felt sympathy for her loneliness. After several weeks, the recollection of that scene remained with him, and he has used it frequently to reorient himself in the family situation in an attempt to reach out to his wife and to counter the isolating structure that had developed.

Another family session involved a mother and father and their twin daugh-

ters who were then 16 years old. In the session, it was clear that there was a coalition of the father and the two daughters against the mother. On playback, one daughter recognized her mother's isolated position and felt very empathetic towards her mother. Following this, she was able to make a new kind of personal connection with her mother, and over 18 months later this new quality of relationship still persists.

During a family session with a mother and father and their five-year-old son, the son kept trying to gain his father's attention while the mother was talking. The father continually avoided his son's attempts, and tried to act as if he was unaware of the son's presence. On playback, the father recognized immediately how he was avoiding his son but said that at the original time he was completely unaware that this was going on. The recognition gained during playback has remained, and the father now is much more receptive to his son and is more sensitive when he begins to disconnect and withdraw.

A final example of lasting impact will be given, although it does not really fit into the patterns described already. This example cannot be adequately explained, only reported. One married couple had a young son age six who, over a period of several years, had a severe problem with chronic constipation. Many medical approaches had been suggested by pediatricians, and still the problem persisted. The mother and father participated in one videotaped session which had great impact for them. Among other things, they became aware of the degree of distance between them and of the great difficulty each had in expressing feeling, particularly anger, in an open and direct way to one another.

The couple worked by themselves for awhile and later reported that the impact from seeing their impasse on videotape had been lasting, and that from that time on they had been able to work more effectively in establishing open communication with one another. What was especially startling was that from the day following that session until the present time, nearly two years later, the son has had no further problem with constipation. One can only speculate that the alteration in the parents' communication, and their renewed efforts at working towards greater understanding in their marriage, resulted in an alteration in the family constellation which reflected itself even in the son's physiology!

CONCLUSION

Since 1965 the authors have used the videotape playback technique with over 75 families and marital couples in their private practices. On the basis of this experience, it is felt that the addition of this tool for providing immediate self-confrontation has made a significant contribution to therapy. Not only does it make immediately available more objective data concerning the therapeutic process, but it also encourages a more intensive emotional involvement in the process of therapy itself. In addition, the nature of the therapeutic endeavor is felt as a more equal and co-operative activity, since both patients and therapists have equal access to the objective record of what transpired. This aspect of the involvement and the co-operative feeling is described by the wife of one couple as follows:

That first videotape session was the first time in therapy that I didn't feel "on trial." You know when you first catch yourself out at

something, I mean that the first time you have to realize that yes this is something negative about you, about one's self, this is a very painful impact. The painful impact of this realization that—Oh! Christ! I am like that. I do do that. I am radiating anger or hostility or I am covering up or something like that—this painful piece of knowledge about yourself that makes you feel so bad. You know, when we were looking back I would see it for myself and the first overwhelming baffled feeling, that sort of all-down-the-drain-punch-in-the-eyes came to me by looking at it. And then when somebody stopped it and said it, the way you said it was so much milder than the way I was already saying it to myself that I hardly felt—I didn't feel at all that you were attacking me, which is the way I felt before. Because you usually were saying it in such a milder way and such a nicer way than I had just been saying it to myself that I was sort of relieved. I didn't feel like you came down on me with boots, but that you were pointing something out very gently. I had already sort of come down on myself with boots. You know, when I saw myself do it, I would say Oh, God! Because of this, when one of you pointed out something to me, it came to me as a sort of helpfulness as a gentle calling to my attention this or that or the other that I felt that I could listen to and felt that I could take it and I felt like I could go on and explore it further and deeper.

The use of the playback also serves to clarify complex behavior patterns and sequences in the actual context of their occurrence, and is especially useful in relating verbal and nonverbal levels and channels of communication within these contexts.

The final point, and the central one as far as this paper is concerned, is that the impact from the playback experience can be both effective on repeated trials over a period of time, and also that the residual effect can be clinically quite significant and lasting and can have a major influence on a person's adaptation over a period of months and even years. In brief, the experience of videotape confrontation can help produce insight of a meaningful and lasting nature. It can also be helpful to a person

in contacting and taking responsibility for his own feelings and behavior, in expressing those feelings more directly when desired, and in maintaining his own direction in life.

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Discussion:

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The paper by Dr. Alger and Dr. Hogan has sociological and psychological as well as therapeutic significance. It is fascinating to learn how therapeutic techniques affect the self-image of the patient in terms of role and status. In the model of organic medicine the patient is put into a "sick role" which increases his dependency, exempts him temporarily from adult functioning, and requires from him only developmental motivation toward health. He is put to bed, covered, and examined. His nutrition is limited, his chest and his bone structure are X-rayed, he is given medication. This model undergoes certain changes for chronic patients, in whom the observation of a medical regimen requires some self-direction, some doing, and a considerable degree of continua-

tion in the performance of adult roles. In both instances, however, the status of the patient is by no stretch of imagination equal to that of the physician.

This difference in role and status between the therapist and the patient in the organic model is recognized to have negative impact on the self-image of the patient. Hospitals dehumanize patients to the point of taking away their clothes and their autonomy over the use of time and forcing them into dependency on an array of people who are presumed to have specialized knowledge and skills and to know better what proper behavior should be than the patients themselves.

The first break in the stratification of health care occurred in dynamic psychiatry; in that field the patient became

to various degrees the collaborator of the doctor. The stratification is still pronounced in the classical analytic model in which the patient is asked to lie down while the physician maintains a sitting position, but at least the patient is co-researcher and co-historian with the physician in the task of detecting developmental experiences which have gone into the repression. And he is also collaborator with the physician in working through these experiences.

In psychotherapy and in casework, the patient becomes the therapist's partner in conversation. His status is still somewhat reduced. He does not sit behind the desk but in front of it. He is supposed to answer questions. Still his head and that of the therapist are at the same level. The supine position of the patient is taken out of the therapeutic situation, and he has the appearance if not the status of equality in a therapeutic system.

In the confrontation with self provided by videotape, the patient plays the role of co-diagnostician. One must compare the situation only with a non-medically-trained patient watching a doctor looking at his X-rays or at his electrocardiogram to appreciate the difference. That such role-playing should improve the self-image of the patient as somebody who can diagnose the maladaptive effects of his own behavior can hardly be questioned. That people whose self-image has experienced improvement will be able to become more giving in interaction and thereby able to elicit more positive responses from their interactors appears highly probable. We can therefore conclude that a technological invention has been so integrated with psychodynamically oriented practice that its very use is likely

to produce an improvement of interpersonal competence.

An interesting phenomenon that is related to the role and status improvement of the patient resulting from this introduction of new technologies to family therapy is the apparently beneficial consequence of "labeling." In two instances Dr. Alger and Dr. Hogan relate improvements in the patients' ability to conceptualize idiosyncratically their own behavior. Concepts such as the "anxiety cycle" and "chicken-pox voice" indicate another experience of power over the human condition, the power of conceptualization. The patient does not only become a co-doctor; he also identifies a syndrome or at least a symptom. To my mind this opens an interesting line of inquiry. I wonder how often such labeling plays a significant role in bringing about improvement without catching the attention of the therapist at all or sufficiently to be recorded.

Of special significance is the opportunity offered by this new technology to children to play the diagnostic role and to identify with the physician. One of the greatest problems of parent-child relationships in the United States is the conflict between our democratic value system and the essentially nondemocratic character of the family as an institution. Irreparably separated from one another by age, sex, and developmental attainment, parents and children are hard pressed in any search for equality or reciprocity in which they may engage. The therapeutic enterprise in family therapy provides such an opportunity. Being visual, interactional, and holistic, concerned with feelings rather than with the manipulation of symbols, the events in therapy and their evaluation when presented as video televised material

work toward the equality of parents and children in diagnostic and therapeutic efforts. This is suggested specifically in the session involving the parents and their adolescent twin daughters but it is likely to be found also in other instances and with younger children. The developmental meaning of such experiences in a democratic setting opens up vistas for the potential of a myriad of

experiences even outside of the therapeutic setting.

In summary, it seems to me that modern technology and its imaginative use by therapists are likely to have the effect of producing in modern civilization something that could be called a therapeutic community that will be infinitely more comprehensive than the most ingeniously run hospital.

Discussion:

by Arthur Center, Ph.D.

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I should like to comment in two areas suggested by the paper of Drs. Alger and Hogan: (1) technical problems in videorecording technique, and (2) likely areas of research using videotape.

TECHNICAL PROBLEMS INHERENT IN THE VIDEOTAPE TECHNIQUE

The incompatibility of videotape recorders marketed by different manufacturers provides problems for the interchange of tapes. One should take this into consideration before buying or using equipment. It is of importance to obtain high quality equipment and in particular to arrange periodic maintenance and servicing. Equipment breakdown is not conducive to efficacious playback and self-confrontation. Also one should not neglect the quality of the audio end of the recording, for poor microphones, their improper placement, and the inability to screen out background noises can render an otherwise good videotape ineffective.

There is a tendency to try to make the television recordings through one-way screens or some other means of a "hidden" camera technique. I suppose this practice is a natural follow-through from the traditional use of observation rooms and screens and the unobtrusive placement of audiorecorders and microphones. In my experience, however, patients tend to ignore a visible camera and its operator unless there is movement of the camera and associated activity by the operator. The trouble with recording through the one-way screen is the relatively poor quality of picture because of light reduction. Videotaping through a small clear glass area is far more effective and the visibility of the lense end of the camera does not seem to bother patients. In any event, patients should be informed that a videotaping is to be done and permission sought for this procedure. When permission is granted, it seems unnecessary to go to such extremes to hide the camera, oper-

ator, etc. (for more discussion in the area see Wilmer⁵). In our groups at Iowa, when the camera is openly used the camera operator has come to be accepted as part of the therapy group as much as a trainee-observer might be and is expected to serve the group for playback procedures.

For many situations a fixed camera arrangement with a wide-angle lense will serve the purpose quite well, requiring no special operator except the therapist himself. Dr. Alger's suggestion of obscuring the equipment behind a cloth mesh screen (within the focal length of the lense used) is an effective method of reducing the distraction that might be offered by the equipment without hiding the fact of recording from the patient. More elaborate two- and three-camera arrangements for different angles and views are possible with the proper connecting and synchronization devices. Cameras that have monitors built in them are relatively expensive. I solved this problem by utilizing a small portable television set (4-inch screen types) that can be handily strapped to the camera tripod or perched close to it. This is a more flexible arrangement in that it also provides an additional small monitor for playback viewing or testing camera locations, fields of view, and operational status of equipment.

Finally, if one intends to study the *audio* portion of a videotape session repeatedly or to transcribe it as a script, it is suggested that an audiotape recording be made simultaneously and independently of the videorecording. This permits the repeated playbacks of the audiotape without the necessity of running the videotape machine and reduces unnecessary wear on videorecording heads. Besides, it is much simpler and

quicker to accomplish transcripts from the less bulky, easier to control audio-tape recorder machine.

LIKELY AREAS OF RESEARCH USING VIDEOTAPE

Dr. Alger has touched upon several of these areas already but they bear repeating. It should be pointed out that, in general, videotapes are useful for the same purposes for which one might use motion picture films, although without professional broadcast-quality equipment videorecordings do not match the quality of films. However, the advantages of videorecording lie in the speed and relative ease of securing the picture for playback, reediting it if necessary, and the relative economy of the hour-long tape itself. The advantages for research purposes stem from the ability to repeat the visual data over and over. The tapes give one the means to objectify aspects of the interpersonal situation and to reduce the effects of observer bias. Thus they have implications for the study of any therapeutic intervention that is dependent upon the observable behavior of the participants—both spoken and unspoken behavior.

The following areas are suggested as lending themselves to videotape research:

1. The study of nonverbal aspects of interaction, kinesis, "body language" movements.
2. The study of autistic behavior involving movement, gestures, symbolism.
3. The study of the associations and memories initiated by confrontation or playback, after short and after long delays.
4. The study of observer or rater accuracy by controlling and being able

to repeat identically the samples of the behavioral events being rated or judged.

5. Self-confrontation impact and effects in special types of cases, e.g., obesity, motor tics, hysterical dysfunction, acute alcoholic or drug intoxication.

The whole area of self- and cross-confrontation by means of videotape offers many intriguing possibilities, whether it is designed for pairs, small groups, or the solitary individual. The evidence provided by Alger and Hogan and by others reported in the recent literature is convincing that self-confrontation may have a beneficial impact or facilitate the progress one makes in psychotherapy.¹⁻⁴ However, before we proceed much further in the development of the techniques and argue for their widespread adoption, we need to direct efforts toward the inauguration of more systematic and controlled studies. We need to be able to parcel out what there is about the videotape techniques in its many facets that contributes to the progress or retardation of therapeutic goals. What conditions of the videotape recording besides those of the therapists own behavior and what other conditions of the therapeutic environment produce favorable results? Which among these produce unfavorable results? Is there a condition which would lead to deleterious results if self-

confrontation were to be used? Not all forms of psychotherapy can be demonstrated to be beneficial. Some may even be harmful for any particular individual in a given situation, but how to predict which type of outcome?

One could extend the possibilities for studying role-playing techniques by use of videotape. Here the roles played by therapists, patients, or even instructed "actors" following a script could be reviewed in playbacks for "confrontation" effects.

Other types of researchable problems in psychotherapy will suggest themselves to any one using television recordings. Add to this the facilitation of research in teaching methods and psychotherapy techniques, and one can begin to appreciate the possibilities in videotape.

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FILMED CASE MATERIAL: EXPERIENCE OR EXPOSURE?

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In the conflict arising as a result of the increase in audio-visual case recordings and the mounting concern about protection of patients' rights, contributions from the experience of the medical and legal professions may forestall law suits as well as serious limitations on the availability of such case records.

The case method has been an essential educational technique in every mental health profession, and for 30 years audio-visual techniques have been an established practice in extending the case method approach.^{2, 6, 10, 11} Recent developments in technology are multiplying the possibilities that these techniques will bring about invasions of privacy.^{8, 14} Not only is there an explosion of filmed and videotaped case material, but the definition of a case is expanding to include groups and even neighborhoods. Whereas it used to be unlikely that care givers would recognize care receivers, such identification becomes increasingly

possible as both training facilities and audiences enlarge.

Besides minor embarrassment and anxiety, what are the dangers to the person whose photograph becomes a matter for professional scrutiny? He may be exposed to ridicule or defamation of character. He may be exploited to the point of "outrage, mental suffering, or humiliation."⁷ Westin,¹⁶ who has written a thorough review of the threats to privacy, speaks of the seriousness of penetrating the "inner zone" and probing a person's "ultimate secrets." If the individual's protective shell or mask is torn away and his "real self is bared to

This paper and the discussion that follows were presented together at the 1968 annual meeting of the American Orthopsychiatric Association, Chicago, Illinois.

a world in which everyone else still wears his mask and believes in masked performances, the individual can be seared by the hot light of selective forced exposure." Westin reports that suicides and nervous breakdowns have resulted from exposures by government investigation, press stories, and even published research. What protections exist for patient and for professional to avoid these alleged consequences?

The fact is that there are no clearcut legal guidelines that establish the boundaries and limits of privacy and describe what is meant by invasion of that privacy. The issues become, then, moral and ethical ones. These cluster around two areas: consent for obtaining the filmed clinical material and assurance for the maintainance of its confidentiality.

Without explicit guidelines, the individual professional teacher is left with the responsibility for making a series of value judgments. How can the professions promote the most considerate and the wisest judgments? Before there is actual harm or legal encounter, what steps can be taken to surmount the hurdles of the electronic age? In Massachusetts recently there has been a great deal of attention in the press to a film, released for public entertainment purposes, about patients within a hospital for the criminally insane. The general public was swept into controversies about invasion of privacy, about the conditions in mental hospitals, and about the political reverberations from these efforts of a filmmaking social reformer. It is hard to justify publishing photographs of institutionalized psychotic patients even in an effort to improve their care, but such use cannot be tolerated when the aim is profit for the film pro-

ducer and theatre owner. But whatever the merits and demerits of this recently publicized film, it has succeeded in giving dramatic coverage to the conflict between the right of the public to be informed and the individual's right to privacy.

This conflict is an old one, inevitable in a democratic heritage. Personal rights have not always been favored as they are now. The Constitution and the Bill of Rights as well as early legislation stressed property rights more than personal rights. Not until late in the 19th Century was the climate such that the right to privacy became a concern. An article by Warren and Brandeis¹⁵ in 1890 is still an appropriate commentary:

The right to life has come to mean the right to enjoy life—the right to be left alone. . . . Recent inventions and business methods call attention to the next step which must be taken for the protection of the person.

It is interesting to note that the "invention" to which they referred was the so-called "instantaneous photography." Newspapers were thus able to print candid, usually unauthorized photographs. On this occasion, the photographs showed Mrs. Warren's private social affairs. It represents another instance where an invention has potential for both good and harm and forces society to define the limits of its use. Warren and Brandeis said further:

The common law secures to each individual the right of determining, ordinarily, to what extent his thoughts, sentiments, and emotions shall be communicated to others. . . . The protection of society must come mainly through a recognition of the rights of the individual.

Legal concern for the right to be left alone is a "uniquely American doctrine" not borrowed from English common law.³ During the first half of this cen-

tury there have been several court decisions which forbid the unauthorized use of photographs or information except in regard to a newsworthy event or a public figure. There are laws in most states which protect the confidentiality of information given to medical persons, but these pertain to access by the courts to patient-doctor communications. In the past decade, however, the concern about civil liberties and widespread psychological activities have brought increasing attention to privacy issues. Congressional committees investigating the uses of personality tests and the general concern about computer technology with its mountains of accumulating data have sensitized people to some of the dangers.

In 1958, the Supreme Court of West Virginia held that the right to privacy would be recognized in that state; the injury was not in the publication of confidential conversations but in the intrusion of unauthorized surveillance: "To hold otherwise under modern means of communication, hearing devices, photography and other technological advancements would effectively deny valuable rights and freedoms to the individual."¹⁶

The courts in Ohio and New Hampshire in subsequent years have also contributed decisions about the right of privacy. The most significant decision has come from the United States Supreme Court in 1965 when it invalidated a Connecticut law forbidding dissemination of birth control information. With this decision, the *Griswold* case established the right of privacy as a fundamental right "older than the Bill of Rights."

Concurrent with the changes in the social atmosphere which favor the protection of individual rights, there also have been increasing pressures to obtain

and spread more information about human behavior. The confluence of a visually oriented generation and the potential of audio-visual media for capturing the experience of reality creates unlimited possibilities for clinical teaching. Professional educators recommend that "as much of the teaching as possible should use case material and come from direct contact with patients."¹⁷ The case becomes a vehicle for both understanding theory and learning techniques. Its study provides a significant opportunity for developing observational skills; these observations of a relatively few cases must in turn be the basis for understanding many. Further, the transmission of knowledge, attitudes, and roles which is essential to perpetuation of a profession, can effectively take place in the setting of joint case observation by teacher and student.

To avoid misuse of this confidential information it has been customary to alter the identifying data in case material presented for lecture or for publication. This anonymity is a well-established practice in professional presentations, but there is less chance for anonymity as soon as pictures appear on the screen. Checkpoints, once built into more leisurely medical communications, now become blurred and problems arise because there are more people involved and the communication is more rapid. There are other problems which have always been present in the use of case material. Because of time pressures, the instructor has to weigh relevancy and consider priorities. He is interested not only in accuracy of material but also in its effectiveness. Hopefully, in assembling any teaching material he considers taste and style as well as content. But sometimes these, as well as privacy and

confidentiality, are sacrificed to expediency.

Although recordings of voice alone are potentially as much an invasion as are those combined with visual recordings, they seem not to have aroused as much concern. There are mountains of tape recordings stored in almost every clinical center. The confidential information they contain might be as flagrantly misused as have some tape recordings in government investigations, jury deliberations, marital conflicts, business competitions, and wiretapping. Sound recordings must be accorded the same protection as other case material, but it is the recording of both voice and picture which prompts a greater effort to maintain the balance between individual dignity and academic freedom and quality.

Observations of human activity can now be made practically anywhere, at least on this planet and in its surrounding atmosphere. Materials are increasingly available for simultaneous screening, immediate playback, or transmission and delayed playback. Records can be studied, stored, or used to confront the participants. Cameras can be fixed or mobile, operated manually or by remote control, microphones can send sound by wire or radio, and bright lights are no longer essential. The predictions of 1984 are approaching. Sony has made it possible to record anywhere with inexpensive videotape equipment. The appeal of such equipment is spreading; professional training centers and annual meetings of professional associations are finding more interest and more uses of audio-visual material every year.

Sometimes the enthusiasm for the new techniques gets a bit out of hand. One medical educator brushed aside any

ethical questions about demonstrating patients on open circuit television. He makes the statement that "fear of unauthorized viewing by laymen of the broadcast medical information has not restricted the selection of subject matter." In his eagerness to see the advantages of television he lauds the absence of "FCC rules and university censorship." More recently other graduate medical educators have paid somewhat more attention to ethical concerns.

Obtaining the patient's consent is the crucial step. "There is no violation of the right to privacy when persons give general consent to be recorded or watched as part of a scientific experiment, an educational study . . . as long as the subject is told in advance, the experiment is not one that demeans a civilized society, and there will be no serious harm done to the person."¹⁶ The essential element in obtaining consent is that it be voluntary and that the patient be fully informed about the nature of the procedure and the uses to which the material will be put. How much coercion does a therapist exert on a patient when he requests permission to videotape an interview? How many persons will express their suspicions or fear of embarrassment if, by their reluctance to do what the medical person wants, they fear the loss of the help which they seek?

How does one make sure that the person who is asked is competent to understand all the implications of the consent? For example, patients are not always able to judge how the filming will influence the course of their treatment. With children, as with psychotic patients, a relative must give permission. Here questions have arisen as to a parent's right and ability to decide that, until a child's majority and indefinitely

beyond, no harm would follow filming of his interviews. Is it not desirable, even though a child might not yet be of an age of legal responsibility, that he be accorded the respect which accompanies seeking his consent as well as that of his parents? The actual form on which the subject signs his name may vary but in most cases it needs to be a signed and witnessed agreement between subject and filmmaker carrying explicit understanding about the uses of the recorded material. Generally, the patient grants the permission in the interests of medical information and expects no specific compensation.

Although questions about consent may be intricate, they are more manageable than questions about the uses to which audio-visual records will be put. The issue of confidentiality does not obtain when the videotape of an interview is played back to a family, for example, and erased after each use. As soon as such a recording is preserved, problems do arise. The nature of audio-visual material precludes complete subject anonymity, but personal references, names and unessential identifying data can be omitted or removed in order to protect subjects from inadvertent exposure when this material is shown.

The person who produces a film and is the prime user is most likely to maintain safeguards about confidentiality. Good material needs to be shared among professional teachers, but as soon as the maker hands a film over to a colleague, he loses absolute control over the use of the material. Even less control is possible when one employs a firm to distribute educational materials, no matter how responsible that organization is. Films and their catalog descriptions should indicate those intended for pro-

fessional audiences only. More film libraries could require signed statements about the intended uses before releasing the material; this calls attention to audience restrictions and offers some legal control. It is probably the use of material for purposes other than those understood at the time of filming which causes the American Medical Association to state that "one of the most frequent violations of a patient's right of privacy is the unauthorized use of his picture."¹

It is unlikely that recent communication advances will diminish these dangers in the next decade. One way to avoid involvement with privacy issues and still capitalize on the assets of visual presentations is the use of "reconstructed" interviews. These employ actors to reenact for the cameras an edited version of a previously recorded interview; they can also be completely fictionalized clinical situations. In most classrooms, however, the professional trainee senses immediately the fact that such events are simulated; their lack of subtlety and complexity limit the value of such acted films.

Fictional films can certainly provide insights into human nature. In fact, there are many examples: "Twelve Angry Men" has been widely used to demonstrate group dynamics, "Wild Strawberries" to illustrate the psychology of dreams, and "The Quiet One" to document the plight of a disturbed slum child. There have also been attempts to draw from fictional films excerpts which illustrate various clinical entities, but these latter fall a bit flat when used in the classroom. Well-acted pieces may have universal qualities which make them useful, but it is the unpolished hesitancy or awkwardness of manner as

well as the content in a spontaneous interview which assist the professional person in gaining vicarious experience.

If one decides to undertake the filming of live material for research or educational uses, what professional regulations are available? The AMA Law Department has drawn up sample forms and makes recommendations about procedures to make certain that "A patient has the same right of privacy as any other individual has."¹ Other guidelines have been offered by the World Medical Association in response to concentration camp "medical experiments" during World War II.⁹ The Declaration of Helsinki was adopted in 1964 and applies to persons involved in medical research or human experimentation. Its principles would seem to apply also to making audio-visual records whether these would be for research or teaching purposes. The Declaration calls for "scientifically qualified" persons to conduct the research and "remain the protector of the life and health" of the subject. In filming this would mean that not only the mental health professional person in charge but also the technical director, technicians, editors, projectionists and secretaries must be included among those who are "qualified." Each must be aware of the confidential nature of the material being recorded and for the need to respect the personal integrity of the subject.

In recent years the threat of federal regulations has spurred institutions to establish Committees on Human Studies. Such multidisciplinary committees are charged with supervising the protection of the patients' rights and the maintenance of a vigilant attitude toward ethical issues. Even if such formal structure is not available, each person who makes

and uses visual records should have access to guidance and counsel of his colleagues. Drawing on representatives of the mental health, health, and legal professions to screen material and advise about potential misinterpretation or harmful impact is an effective safeguard.

Transcending all of these available guides and opinions, the most important protector of individual rights remains the integrity of the producer. If the person in charge of the filming is sincere in his effort, is informed about the material and feels genuine interest in the subjects, he can create a film that is an experience for his audience and not merely an exposure of case material. The filmmaker or video director must be conscientious and responsible. He should be capable of instilling similar respect and the necessary professional attitude in his assistants. The producer and the collaborating mental health personnel must be relied upon to keep the tools subservient to human needs. Reusch¹³ comments that:

The world of the past was structured around people . . . the new world is structured around systems made up of people, machines, and the environments surrounding them . . . the individual has become anonymous. . . . Modern rules and regulations are written around the technical product or process rather than around the responsibility of the individual.

Is this another way of saying that the medium is the message and that the medium is dictating the rules? It would be more hopeful to set the protection of these individual rights in the larger framework of the ever present struggle to maintain human values at the same time the machines enable man to cross new frontiers. As Reubhausen and Brim¹² say: "Absolute rules do not offer useful solutions to conflicts in values.

What is needed is wisdom and restraint, compromise and tolerance, and as wholesome a respect for the dignity of the individual as the respect accorded the dignity of science."

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Discussion: The Ethical Hazard

by Sanford N. Sherman, M.S.

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I think it would be useful as a discussion base to describe briefly the history of my own agency's use, and changes in its use, of films—and the ebb and flow of my own views.

In the Jewish Family Service of New York—both in the umbrella agency and in its family clinic—we have had almost 10 years of experience in filming and,

more recently, videotaping actual therapy sessions. We have filmed well over 100 sessions of 60 families and videotaped even more.

In the early years of our filming, before we took proper stock of what we were doing, we were lending films of single therapy sessions all over the country—for educational and training pur-

poses—so long as we were told the viewing group would be “professional.” Gradually, we learned to hem in more carefully the outside use of our films. At the present time, we turn down all requests to send film or videotapes anywhere—except for two edited sequences of therapeutic process. We use film and tapes freely with our staff and trainees within our own institutional walls, but outside those walls we confine their use to a few selected staff who take the recordings along with them to institutes, conferences, or other institutions where they know who the audience will be and where they *personally* use the film or videotapes as case material for their presentations and lectures. In addition to these restrictions on use, we now require signatures of every family member on a release form that is very broad in the rights the patients surrender, a legal document that “protects” the agency.

Despite all this experience, we still do not feel on firm ground. We still are caught in the dilemma of serving two aims: one of teaching, learning, and research; the other, the full protection of the rights of the individual patient or client.

I find Dr. Mason’s discussion a reasoned, judicious treatment of the subject. I can see he too remains troubled and caught in the dilemma, and he has touched significantly on the major issues.

Audiotapes, that is sound recordings alone, do not to my mind, enter into this discussion. Anonymity is so easily achieved in them as to remove them from our present concern. My colleagues and I moved from sound recordings to recordings of sound and image because sound is only one level of communication. To record the transactional char-

acter of therapy process, occurring on many communication levels and modes—to capture the existential experience of therapy—sound and image recording is indispensable. Such recordings have proven so valuable in professional training and have already provided, and promise to provide even more, valuable data for study and research, that it is impossible for me to think of imposing severely handicapping limitations on their use. This conviction in their almost inestimable value moves me in one direction. Moving in an opposite direction and creating the conflict in Dr. Mason, myself, and others is the concern for the rights and privileges of the patient.

Not all uses of film or videorecords give me conflict. When used only for or on behalf of the patient, I see no infringement of patient right or privilege. I have repeatedly seen the therapy of a particular individual or family enhanced by the restudy and reevaluation of recorded material from their treatment; reevaluation that was done by the therapist alone or with the help of supervisors or colleagues. I have also seen profound turning points reached with patients who have with their therapist viewed recordings of fragments of their own therapy sessions.

So the use of recordings solely on behalf of or directly with the patients who are the subjects of the recordings does not raise a dilemma or conflict of interests, rights, or privileges. It is the use of these recordings beyond that narrow limit, for purposes beyond the immediate purpose of therapy of a particular patient, that raises vexing issues. Such use requires more than the therapist’s good intentions; it means the recording be destroyed after it has served the purpose of enabling the therapy of the sub-

ject. In videotapes this destruction is easy: the tape is simply wiped clean. Films—far more costly to produce—must be literally destroyed.

If destruction does not take place and recordings are stored, there always remains the potential of their being used for other purposes than serving the patient. I think there would be no dispute that the storage of therapy session recordings raises the same questions as we raise about recordings that are made by design for broader uses than enhancement of the individual patient's therapy.

Some of the nagging doubts we have in recording for broader use cluster about the question of patient consent. Dr. Mason has touched on the fact that formal consent, even signing a legal document, is not the same as *de facto* consent, for the patient is really not in the position of peer to the therapist. His need of and trust in the therapist neutralize many of the caveats he would ordinarily observe in signing an agreement. There is an element of subtle, unexpressed coercion that the contextual situation and personal relationship impose. Moreover, even the therapist cannot predict with certainty the future safeguards against unwanted exposures and intrusions on the patient's privacy that may occur, any more than he can know who in what future audience of that film might recognize the patients or other persons or situations alluded to in the recorded sessions. Nor can the therapist know for certain that some investigative or policing policy body might not somehow gain access to the recording. The patient can know (or let himself know) even less, far less, than the therapist of what he might be letting himself in for.

An attorney has pointed out to me that professionals are prone to the belief that the concept of privileged communication is to protect them—the professional practitioners—from the necessities of disclosure, but that actually it is a privilege granted not to the professional but to the patient. Privileged communication, whether embodied in statutes or inhering in the professional ethic, thus imposes and sharpens a responsibility of the professional to safeguard a privilege of his patient. Legally, I am further told, a patient-therapist or client-therapist relationship is fiduciary. The therapist is in the role of trustee, and as such cannot delegate his responsibility to another. Therefore the individual therapist and institution cannot on their own entrust their recording of patients to, for example, a film library.

These legal questions parallel the ethical questions which confront us, and for which we do not yet have fully satisfactory answers.

One thing is certain to me. To preserve the great values film and videorecordings have for training and research—purposes beyond the enhancement of a particular patient's treatment—and yet to poke our way carefully in a field mined with ethical, and legal, hazards, we must play it close to the vest:

1. Rather than a free-handed broadcast of such training materials to the variety of groups in our own and other communities requesting them, we must be highly selective. I have all too often seen groups defined as professional which include persons only marginally controlled by professional discipline and even include stray laymen like reporters, public relations people, etc.

2. We have found it practicable to confine outside use of recordings to fully

responsible staff members of our own who personally accompany the recordings and use them as case material for their lectures or teaching.

3. Preservation of recordings for an indefinite period is questionable. An agency can have a rule about the outer limit of time span that it will preserve recordings. One year? Two years?

4. There might be other and additional limits, such as those of occupation or class. For example, recordings of individuals or families in occupations or social strata that are remote from the occupations and class of those persons likely to view the recordings—such remoteness serves a practical safeguard against embarrassing exposures. But they are no better answer to the ethical considerations and in fact bother me by their patronizing smell.

5. Geographic distance is another practical aid, which avoids the possibility of embarrassing confrontations. In a

large metropolitan area, there is less chance of the crossing of paths of patients and audiences. Even less chance inheres in out-of-town viewings.

Such practical steps as I have outlined increase the odds against chance embarrassments. However, a basic question persists, and that is whether we are building pretty rationales for a practice of intrusion on personal privacy that is little different in social consequence from the rationales that law enforcement, investigative, and prosecutory representatives have advanced for their excesses in the use of electronic and photographic intrusions. Their argument has been dressed in the moral and social tegument of protecting society and enforcing law, ours of advancing knowledge and training better therapists, so our society in the end may benefit. Are we hypocritical?

I do not yet have the answer.

DELIVERY OF SERVICES

RESISTANCE TO CHANGE IN MENTAL HEALTH PROFESSIONALS

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A rapidly changing society requires that we establish more responsive models of theory and practice. But mental health professionals often resist looking at totally new models. This paper analyzes the fears of reduced status, financial return, work satisfaction, and feeling of competency that seem to be the cause of such resistance.

Personal satisfactions, contributions to the welfare of others, status, and money have all been suggested as the reasons for entering, remaining in, and contributing to the mental health professions. I suspect that these are also the primary reasons for resistance to change and for the kinds of anxieties manifested by many when our rapidly changing society requires that we become more responsive to community needs and to find more effective, innovative, and responsive models of theory and practice.

From time to time I have examined my own resistance to trying some new method of psychotherapeutic intervention, to considering some new factors in the etiology of childhood mental disorders, or to investing myself more fully in developing the theory and practice of mental health consultation. Mostly I recall pervasive feelings of uneasiness. When recently I was again challenged to teach in a different way and to demonstrate crisis intervention, these old feelings returned. Trying to dissect some of the component parts as I experienced

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them, I became aware of feeling that I would be exposed and unsure in these new efforts, that my contributions might not be seen as unique. As I became more involved with the community and with other mental health professionals, I found that the feelings of constant challenge to my ideas or efforts required me to affirm my efficacy, knowledge, or capacity to resolve problems better than anyone else. Such feelings and behavior often stood in the way of collaboration. I noted also that my most frequently employed defense was one of all-knowing omnipotence, which by implication indicated that a new method or idea was old hat, had been tried before, and had not been effective. It was under these personal circumstances that I began to try to understand my own and my mental health colleagues' resistance to change in viewpoint and practice.

ROLE OF PERSONAL SATISFACTIONS

One's personal satisfactions in the mental health professions depend upon having learned a certain body of theory and practice and becoming fairly proficient in its use. We recognize that with continued use we can become more proficient and comfortable as experts. Most of the current models of interpersonal therapeutic engagement provide a fairly neutral, safe, and uninvolved haven for the therapist. Except perhaps in work with psychotic adults and children, the therapeutic position is one of relative uninvolvedness, personal safety, and power. It is of interest that the recent increase of adolescent inpatients and outpatients has resulted in many problems for therapists because sick adolescents will usually not permit others to remain unengaged. Their demands and harassment for honest and direct ex-

pression of feelings is quite threatening to many on the therapeutic team who are trained in another model.

Personal satisfaction in the work is also very much dependent upon a sense of effectiveness and accomplishment. In many instances in both private practice and agency work, we have some control over the psychopathologic problems or social class of individuals with whom we will work. Thus, we can often select to preserve our feelings of effectiveness. In some settings, relatively brief diagnostic contacts without follow-through give us a sense of helping individuals and families to accept the existence of problems and need for help. We can then make a referral without being involved in further assessment of the effectiveness of the referral procedure or subsequent help to the family. In individual work with children and parents we can, with practice, select the workable families who give us a sense of satisfaction. We can then designate the others as unworkable or hopeless and refer them to agencies or younger colleagues just beginning practice.

In all our work we are intimately involved in the relief of suffering and helping others to live with less pain and turmoil. That we reach only a few people may be troubling, but since we are obviously providing some respite from pain and disability we can feel personally gratified that we are contributing in the best sense to human welfare.

MONEY AND STATUS

The question of how status and money affect our resistance to change brings us to a very touchy area. There can be no question about the importance of status in our society as a whole and the mental

health professions in particular. That they are frequently linked to income is also quite evident.

The paradigm of status in the mental health professions is the psychoanalyst. For a number of historical reasons having to do with the development of the most comprehensive, meaningful, and transmittable body of theory and practice, psychoanalysts have in one way or another been our most influential and effective teachers and models. Therefore, the model of individual work with patients for a 50-minute hour, the couch, and high hourly fees has become the zenith in mental health practice. It is little wonder that individual work with patients in private practice has become the symbol of status in psychiatry, psychology, social work, and even psychiatric nursing. Licensing acts in various states to permit nonmedical private practice with the mentally ill have the psychoanalytic model in mind.

Money is clearly most easily come by in private practice, where you can be your own boss and can be adequately recompensed for long years of training. There can be no quarrel with the human need to a good income and the comforts and status that come with it.

UNCERTAINTY AND RESISTANCE TO CHANGE

The body of theory with which we work and the assumptions upon which they are based are usually not made explicit or tested carefully in practice. However, pragmatically they seem to work since patients keep coming and many appear to improve. Thus, a kind of certainty and security about one's theoretical and practice models occur without much challenge, except as occurs with individual patients with whom

we are not very effective or who disrupt our complacency by refusing to fit into our particular formulations. With such patients we can usually talk about resistances, and then find someone else we can work with more easily without needing to reexamine any basic premises of our theory or practice.

For most of us, uncertainty is anxiety-provoking, questioning of our basic premises is threatening, and evaluating our work so we can continue to learn and grow is frightening. It is of some interest that the psychoanalytic model of the analyst's ongoing self-examination to ensure that he stay attuned to his own internal unconscious interferences in work with patients, as well as his continual assessment of the effect of his interpretations on the progress of the patient, are basically the scientific model. In the scientific model, close scrutiny and testing of all possible variables are essential, in addition to frequent re-assessment of the basic hypotheses as the evaluations of actual practice or experiment shed light or raise questions about underlying premises. It is unfortunate that this model, while in theory an excellent one, is infrequently adhered to in practice. In fact, it can be said that those psychoanalysts who do adhere to it are at the forefront of reexamination of theory and practice. They are the most open to new evidence in all the behavioral sciences which might shed light on their basic hypotheses. They also tend not to be doctrinaire and therefore lead the way to new formulations in theory and practice. For most of us it is easier to find a niche and stay there; the anxiety, wear, and tear are less and the security is greater.

I also suspect from some recent investigations in a variety of professions

that one major obstacle to change and use of new methods is a fear of discovery that one is not as competent or effective as one had hoped. All new learning is hazardous as well as anxiety-provoking when it involves unlearning old methods and developing new skills.

The teaching of new methods and procedures to trainees finds teachers trained in old models resistive. To look anew at our methods and basic hypotheses, to begin to evaluate what is true and helpful in the old, what can be translated to new situations, what are the immediate and long-term results of both old and new methods, of necessity engenders anxiety. In education, engineering, medicine, the mental health professions, resistance to change sometimes takes the form of acknowledging the relevancy of new ideas and methods but not accepting them in practice or trying them out fully in new training and practice areas. A case in point would be the concepts of community mental health centers—continuity of care, responsiveness to the community's need and priorities as well as involvement with the community, the development of new treatment modalities and personnel,—which are often officially subscribed to but rarely carried out fully.

RESISTANCE TO CHANGE RELATED TO ALTERED STATUS

One of our most serious internal team problems as mental health professionals is now reflected in new mental health programing. Leadership devolves automatically upon the high status psychiatrist, by tradition and because of the issue of medical responsibility, despite the fact that other team members may be more effective administrators or more skilled community mental health workers

and that consulting physicians could carry the medical responsibility. In community mental health centers, competence and effectiveness in doing the job should be the issue.

In new mental health programing a variety of professions as well as non-professional community representatives all want their say. Since they may be more aware of the needs, priorities, and methods by which a particular community could be served, many mental health professionals view this involvement of others as a threat to their status as experts. In one community setting, as an example, the mental health professionals were experts in providing one-to-one psychotherapy to children and their families. In this poverty area, the community representatives, local residents, church leaders, school personnel, and juvenile court workers expressed the need for more effective and widespread interventions in the first years of school. They felt that school failure which continued into the third or fourth grade usually resulted in total school and job failure for their children. The community representatives and professionals asked the mental health workers to address themselves to these concerns. The mental health professionals had first to resolve their feeling of threat at "being told what to do." After prolonged discussion, they came to accept their area of expertise as "how the tasks should be done." But only after this resolution of threat to their status were they able to become engaged with the community toward a mutual goal of more effective educational and mental health services for a high-risk population.

EVOLUTION OF MENTAL HEALTH CONSULTATION IN SCHOOLS

Another example: In the face of the

acute shortage of mental health professionals in a school system, it was suggested that individual services be kept at a minimum. Instead, it was proposed, the mental health workers might learn to use consultative techniques to enhance the capacities of counselors, teachers, and administrators to work more effectively with an ever-growing population of disturbed students.

Resistance to learning such mental health consultative techniques became evident when many of the workers began to raise the question of who was going to provide such services—social workers, psychologists, or school nurses. Each professional group wanted to have an exclusive franchise in exchange for giving up their already well-developed and sought-after skills in individual services. Learning to be a consultant meant parting with the role of advice-giver and dispenser of favors (ridding the educator of a disturbing child). It meant involving the educator as a collaborator and withstanding his anger when, instead of removing his problem, the consultant engaged him still further in the problem. Consultants had to work together with educators in securing the necessary data to understand a child's learning and behavior problems and in evolving a method of working with the child and family which might enhance the child's effectiveness as a student and reduce disturbing behavior. Only over a period of several years, when the consultative methods were acknowledged to be effective by school personnel and the special skills of each profession were utilized and recognized, did the status problems diminish.

USE OF SUBPROFESSIONALS

In the area of training and use of non-professionals, innumerable status prob-

lems occur. Despite the acute shortage of professionals which can never be overcome, stresses appear as aides are trained to do part of a particular mental health job and begin to do it well. We are all threatened with loss of status when our job function is no longer unique and we are fearful that someone can replace us. It becomes difficult to accept a coordinating function, a consultative and teaching role, as we note that a meaningful therapeutic relationship can be established and maintained by indigenous workers and case aides. Our role of supervisor, consultant, and emergency trouble shooter, which makes the subprofessionals' work effective, seems less gratifying since it is removed from a direct sense of effectiveness with the client or patient.

PROBLEMS WITH NEW MODELS

Perhaps most striking is the resistance to looking at totally new models and concepts of therapeutic intervention. The public health model, which considers population problems and seeks methods for alleviating these, is threatening to those of us trained in individual work. The request to translate some of the concepts we have learned in individual, family, and group therapy to deal with a wider range of problems and for more people evokes anger in many of us. When asked to concern themselves with primary and secondary prevention rather than with refining treatment methods, mental health professionals often take the position that this is not within their province. To become competent in these areas requires a new conceptual framework which utilizes dynamic mental health concepts garnered from psychoanalysis, dynamic psychiatry, social work, and clinical psychology.

As a member of a new team, the

mental health professional may need to relinquish his autonomy and learn a new kind of collaboration with a wide variety of health, education, and welfare allies. Many of us are poorly prepared for such a role and require considerable encouragement and role models in our professions to make a new role appear worthwhile and acceptable, despite our convictions that it may serve more people more effectively.

In one school district, to illustrate, it was possible to get all the mental health personnel involved in developing consultative and other interventions in the school and community because the crisis in the community would not permit them to deny the failure of the traditional methods to do the job in the face of overwhelming problems. But the transition from effective individual practice to effective mental health consultation with teachers, counselors, and administrators, to group work with children and parents, to involvement with Head Start, kindergarten, and primary teachers, aides, and parents in a prevention program required development of pilot models. As these models became viable and effective, other mental health and school personnel were able to learn from them. Weekly process seminars helped to explore how these methods could be used and helped test new ideas. Not only were successes shared, but all the problems, doubts, and anger about feelings of inadequacy and helplessness in the face of community pressure could be talked about early. We came to understand our turmoil as we sought to learn new methods and to find our satisfactions in new and different indicators of personal effectiveness.

For example, teachers' and school

administrators' realistic concern and feeling of being overwhelmed by the continuous confrontations from angry, disgruntled Negro and Mexican-American students in several junior and senior high schools led to ongoing discussions during the seminar about these issues. It became clear that the mental health professionals were uneasy about the anger and confrontations presented to them by teachers, counselors, and administrators but were reluctant to voice such uneasiness. As the seminar group became able to discuss their feelings openly, they began to look at the data presented by school people and by students. The issue of how one could avoid confrontation and its threat to one's position of authority and how one could begin to turn confrontations into collaboration bore fruit.

In one school, the worker, who had excellent relationships with both administration and teachers, was able to open discussion of how they could gather data about how best to serve their students, since they were aware of student dissatisfaction and needs. This led to dialogue between teachers and students, and among teachers, students, and administration for ways of making the curriculum and the school experience most meaningful. The actual efforts to change both methods and curriculum reduced tensions in the school and led to developing a method of continued, regular dialogue at all levels and provided a model for other faculties and consultants to strive toward.

An evaluation program to determine the effectiveness of consultative methods finally convinced some mental health professionals that they were having some impact. It seemed that the subjective impressions of the educators and com-

munity representatives who believed more school children were staying in school and learning were not sufficient. It was as if, having given up their traditional methods of work, they had also temporarily lost any way of validating their usefulness. The reassurance which they had previously found adequate, such as statements from clients, patients, or colleagues, in this instance, no longer sufficed. Evaluation, with clear controls and mutual engagement of all concerned in developing criteria for effectiveness, resulted in a much greater sense of involvement and personal satisfaction.

Several part-time workers gave up or reduced their more lucrative private practices as they actually experienced being effective in using new methods. Comments were often made about the feeling of strength, satisfaction, and sense of involvement resulting from participation in a community effort. There also seemed to be an overriding sense of purpose in the joint efforts to reduce disability and enhance the productivity and capacity for more effective living of chil-

dren and parents in the community served.

SUMMARY

Mental health professionals resist change because such change may reduce their status, financial return, sense of personal satisfaction, and feeling of competency. Learning new methods of working, and especially using new models like public health concepts, are threatening to our established and already learned theoretical frameworks and practices.

Community involvement because of crisis situations may force new learning upon mental health professionals. Pilot programs which provide models for both theoretical understanding of the work and the methods of practice are helpful. Continued group discussions to talk out problems and planned evaluation of new practices also reduce resistance and encourage more effective innovative practices. Finally, effective involvement with a community brings its own satisfactions to mental health professionals.

THE CHANGING POSTURE OF THE MENTAL HEALTH CONSORTIUM

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The structural relationships within the consortium of mental health professions may be viewed as a temporary means of meeting the political and social demands for prevention and treatment programs. The strategy of adopting an equalitarian set of role relationships within the consortium may be a passing one, given the likelihood of vertical structuring in order to maintain organizational arrangements.

Not much more than half a century ago, a man and his ideas provoked the development of a new health specialty—one that emphasized different concepts and expanded the vocabularies of health practitioners to include such terms as "adjustment"; one that has concerned itself intensely with problems of communication and the patient-practitioner relationship; one that has shifted the search for the causes of illness at least somewhat away from the germ; one that has excited large numbers of persons about the prospects of manipulation

leading to changes in the individual; and one that has been attacked by some as a totally charlatan activity and embraced by others as an essential component previously absent in health care.⁵ The specialty under discussion is essentially a social invention. Probably, like other inventions, it was discovered many times before, but remained obscure and dormant because of a lack of structural readiness by the community to adopt it.¹⁶

There was a man and an idea, but also a style and organization to com-

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munity life at the beginning of the century that converged to render viable this new specialty. Daniel David Palmer and chiropractic therapeutics came along at a time when the small town and rural midwest community members, with their Protestant-ethic orientations, were ripe for a new mode of health care. Its acceptance and development stems from structural circumstances: like the wheel, the airplane, and the bagel knife, it is an idea that may have been thought up many times but never, in one sense at least, really invented before. The same almost certainly is true of psychiatry and all the little psychiatries that go by other names.

THE EMERGENCE OF THE CURRENT POSTURE

The field of mental health, and the development and growth of the consortium of professional groups involved in it, is rooted in the attractiveness of ideas and practices compatible with a period of marked technological change, of expanded emphasis on educational and intellectual attainment, and of intense concern with economic achievement, material objects, and a bourgeois style of life. It also was a period when concepts of philanthropy were changing.³ The sweet little old ladies in their black straw hats were being replaced by paid do-gooders. These neophyte professionals with unashamed aggressiveness sought a body of knowledge that could be transmitted to new recruits, if only so they might enjoy a modicum of respectability and a small degree of riches. Then too, in the academic world, the subject matter of the social studies was rapidly changing, and disciplines were realigning themselves. Psychology received explicit recognition as a legiti-

mate subject in circles of higher education, eventually with the prerogative of training persons as practicing clinicians.

Perhaps the structural-functional perspective is less than an adequate explanation for the development of new health specialties. Certainly, however, the persistence and robustness of health specialties stem from their remaining in harmony with the social order, in the same way as modifications and adaptations are provoked elsewhere by structural changes. The revision in name, for example, of the American Board of Dermatology and Syphilology to the American Board of Dermatology that occurred in 1955 represents an emphasis on skin condition and appearance among a wider segment of the community. Likewise the growth of the practice of orthodontics can be reasonably interpreted in this way. The proposition that all of health care, particularly mental health care, represents an expression of the structural character of community life is not an original one. Iago Galdstone⁴ has observed that since antiquity the organization of medical care and the provision of health services, whatever they may be, have reflected the social, political, cultural and economic character of the community.

In all of medical practice the current pressures of the social order are provoking intense concern about existing modes of delivery of service and task allocation among medical care personnel. The growing "radical left" among physicians are committed to challenging both the way health care is conceived and the way it is undertaken. They have proposed major alterations in present programs. Within these ranks it is held, for example, that the organization and coordination of medical care services can-

not focus on illness alone, but on health and illness, and these in the community, the hospital, the home and the agency. Moreover, it is deemed critical that comprehensive program development include and encourage the participation of the recipients of service. As one of the leaders in community medicine has noted: "We are faced now with the task of teaching techniques we have not yet mastered to thousands of subprofessionals we have not identified to meet needs we do not fully yet understand in a pattern of organization we have not yet invented."¹¹

Furthermore, there are some special considerations in the prevention and treatment of mental illness that link the stance of the field to social, political and ideological factors.⁷ First, there is a long-term awareness of the association between characteristics of the social order and the mental health of community members. It is not only recent work such as that of Leighton and his associates that emphasizes this view.¹³ As George Rosen²¹ has brought to our attention, Benjamin Rush in the eighteenth century informed us that mental health required a stable and ordered society which would provide the proper stimuli and the necessary conditions of well-being.

Second, and the point must be faced, the mental health field particularly is conspicuous in the absence of scientific investigations that demonstrate persistently and convincingly the efficacy of its existing preventive and treatment programs. As a consequence, the field is unusually vulnerable to social change.⁶ Ullmann puts the matter quite sharply in an analysis of institutional treatment in a number of psychiatric hospitals:

The effectiveness of the treatment staff might be improved in much the same way as a monkey pounding on a typewriter can be helped to locate the works of Shakespeare. That is, we can increase the hours the monkey types (i.e. reinforced time with patients and decreased administrative ventures), or increase the number of monkeys engaged in typing (i.e. increase treatment staff through increased or more selective expenditures). However, even as with the monkeys, someone would be required to separate the poetry from the meaningless letters. While there is some value to "more of the same," the addition of something new seems to be called for.²⁷

Third, the concept of mental health itself continues to be challenged in many quarters. At best it is viewed as a vague and ambiguous one, at worst as meaningless and without any real reference to conditions in the "outside" world.²⁴ And if the fragile constitution of this concept were not enough, it is also strikingly susceptible to a variety of usages and interpretations when differential weights are attached to various dimensions, depending upon the social characteristics of the community members involved.⁸ Myers and Bean,¹⁷ for example, in their recently published 10-year follow-up study of former mental patients, identify social class differences in the relationship between the manifestation of psychiatric symptoms and the individual's overall performance in work and other instrumental tasks. Upper- and upper-middle-class patients over a 10-year period apparently do not experience either greater social isolation or employment and financial problems than others of similar class status who have not undergone a period of hospitalization or outpatient treatment. But among those of low social economic status in the community, mental illness apparently is catastrophic for both the patient and his family; it is among the poor that the impact of the illness is maximally

related to serious employment and financial problems and a high degree of social isolation.

Finally, whether the underlying reason is one of the selection process, i.e., who chooses a career in mental health, or of the socialization experience during the early stages of professional development, a significant number of individuals within the consortium of practitioners are strongly oriented toward immediate and, if necessary, unconventional social action in order to ameliorate undesirable inequities and disorganization in the American urban community. The value orientation being described is illustrated well in the writings of such persons as Robert Coles.⁴

In brief, it is not the "mental health movement," as some may think, that is responsible for the state of affairs in the field, but the current outlines of the social order.²³ In many ways, the characteristics of contemporary mental health practices and the roles taken by practitioners are inconsistent with new and projected needs, and this has led to what may be politely described as a field in a state of "flux."

Given the current demands—concern with the poor, the growing aged population, the drug-using adolescent group, and so on—the traditional lines of demarcation between the various practicing professions have blurred; reliance on a particular mode of therapy is regarded as futile; role assignments of individuals are no longer sharp; and status relationships within the consortium are unclear. A portrait of the mental health consortium would resemble pop art in the extreme, or a frame from "Bonnie and Clyde." On the one hand, there are medically trained persons who share long years of relatively similar

training and extremely rigid certification requirements. On the other hand, there are the innovative groups, such as aides recruited from among the poor to meet the needs of persons in poverty areas, who have little in common with each other or their professionally-certified practitioner colleagues. At the same time that psychodynamically oriented social workers are busily reviewing the relevance of sociological theories for mental health programs, psychometricians are occupied with the stresses of administrative positions in new appointments, as directors of mental health centers and catchment areas, formerly opened only to physicians. And child psychiatrists are busy learning about cost-effectiveness analysis and systems design so that they may prove competent as social planners.

The changes have been truly phenomenal. At an organizational level, the distinguished British expert Richard Titmuss noted:

... this blurring of the hitherto sharp lines of demarcation between home care and institutional care, between physical disability and mental disability, between educationally backward children and so-called "delinquent" children, and between health needs and welfare needs, is all part of a general movement toward more effective service to the public and toward a more wholistic interpretation and operational definition of the principles of primary, secondary, and tertiary prevention.²⁵

The picture emerges sharply when the specific functions of mental health personnel are considered. It is now possible to legitimately act as a psychotherapist without participating in the long training traditionally required;¹² the person formerly regarded as a non-professional or limited practitioner not only may assume therapeutic roles and responsibilities but, as he does so, the distinctions between ranks are further obscured. In some cases the nonprofes-

sional worker in the mental health field has become so much a part of the therapeutic team that he or she is reported to end up by teaching the professionals charged with training her.¹⁹ Furthermore, the urgency with which some mental health professionals are engaged in rethinking and redesigning their current role assignments in search of more distinctive professional niches provides additional testimony to the increasingly flimsy role definitions which currently characterize the field.¹⁰

It seems clear that we are approaching, at least to some degree, a situation where all organizations are multi-service ones, where all categories of personnel offer and undertake a variety of prevention and treatment activities, and where all people are welcomed and encouraged to participate in the spectrum of programs. At first glance, perhaps, it may seem that the changes that have occurred signify the arrival of the millennium. It would seem that what is developing is a system of health care in which democracy is being expressed at an organizational level both in relationships between treatment personnel and in participation of community members in programs. But before one may embrace the current scheme of things with enthusiastic abandon, it may be useful to speculate on the consequences of the current posture and on the course of future events.

FUTURE ARRANGEMENTS WITHIN THE CONSORTIUM

A discussion that ensued in one of the sociological journals some years back has considerable relevance for our views on future arrangements in the field. It was a debate between three esteemed sociologists.²⁶ A publication by Tumin

inquired into the possibility of a social system being completely structured along a horizontal axis. He argued quite forcefully that, theoretically, there is no reason why it is not possible to realize this type of social order. His point of view that vertical stratification is not endemic to social life was challenged by both Davis and Moore. They are at least equally persuasive in their argument that while it is possible for a society, community or organization to conduct its affairs with all men being equal, inevitably it will be necessary for some to be more equal than others.

It is not critical to settle the debate here, for even if Tumin were correct in the abstract, the concept of a flat, horizontal system within an organizational entity is extremely difficult to imagine within the context of contemporary American life. Yet, apparently, this is the direction of development within the consortium of mental health professionals.

Is there a basis for concern, given the proposition that all may be equal but some must be more equal than others? It would seem that, to the extent that a horizontal arrangement is both a feasible and an appropriate way to organize relationships within the mental health field, a reformulation of role relationships and task assignments must necessarily be within an overall plan. But this is not so in the case of the consortium of mental health practitioners. Indeed, if one wishes to be either cynical or snide, it can be argued that the present arrangements and the direction of relationships within the consortium stem from the inability of the parties involved either to do their own jobs better than other people, or other people's jobs better than theirs.

The increasingly vigorous argument that medical training is a dispensable component in the psychotherapist's toolkit demonstrates the extent to which functional monopolies of therapeutic tasks and activities are becoming problematic.¹⁵ Professional attributes formerly used to separate the various roles and functions within the consortium seem to be losing their sanctity as the boundaries between the professions become more permeable and the tasks of each one less rigidly defined. The cry is heard, in this regard, that jobs be assigned according to "competence" rather than "professional identification".²² But the formulation of criteria by which therapeutic competence may be ascertained continues to remain as vague as ever. This seems especially apparent in the organization of therapeutic communities, where it is held that "Every team member is encouraged to use *whatever* therapeutic skills he possesses in *any* situation. [Emphasis added.]"¹⁴ If the parties who traditionally have occupied the superordinate roles were in fact distinctively qualified for special positions—psychiatrists in comparison with everyone else, and degree-holding professionals of various ilks as opposed to attendants, aides, and intelligent laymen—it would have been difficult, if not impossible, to wrest these persons from their niches. The trend towards "equality" and task disbursement within the consortium of mental health practitioners may be looked upon as a most brilliant *ad hoc* strategy, albeit unwittingly arrived at, which may function, literally, to prevent a revolution within the ranks of the disadvantaged among the consortium: a victory, indeed, if one thinks about the possibility of the gatekeeper

recruited from the poor snuggled on the clinical director's couch by popular vote.

One means by which persons in high-status occupations protect their positions is to monopolize certain functions, and to maintain this monopoly by means of a series of legal and formal mechanisms of certification. A consequence of successfully developing such certification procedures is a built-in incapacity to be flexible and to move rapidly in reorganizing the educational and training programs for their numbers. Despite the obvious successes of the Martin Luther Kings, Stokeley Carmichaels, and the like, psychiatrists, even today, are telling us that:

Clinical training, with continued clinical work, not only sensitizes one to transference and countertransference problems of individuals and group psychotherapeutic work vital to self-awareness in all personal situations, but it also keeps one focused on the individual human being and his needs and reactions to programs and process. It also makes it possible to utilize clinical acumen in all of one's interpersonal relations at all levels.²

While training in the entrenched mental health professions like psychiatry apparently is resistant to change of significant proportion, practice in the field seems to be demanding role versatility of considerable magnitude. The successful mental health professional may soon be distinguished from the unsuccessful one primarily by his virtuosity as a quick-change artist. It is simply foolish to hold that the astute clinician makes the best community organizer, that lengthy practice experience with neurotic middle-class housewives is useful in the development of comprehensive health and welfare programs for the poor, or that success in treating the school phobia problems of suburban grammar school kids gives a purchase on dealing with

school dropout and drug problems among core-city teenagers.

Of course, there have been modifications in the educational and training programs of those who are or at least were high up within the consortium of health professionals. But it is fair to state, by and large, that most of the educational innovations have occurred within the less respectable professional groups or in disciplines based on almost entirely new academic programs. In simplest terms, the trend toward egalitarianism and the sharing of roles and tasks may be viewed as a means of possibly avoiding even more marked rearrangements in patterns of relationships within the consortium of mental health practitioners.

The trend toward equality and the sharing of tasks may, of course, be defended on the grounds that the reduction of status differentials and a lack of rigidity in the therapeutic contributions of the various parties involved is desirable in keeping with the wholistic philosophy of treatment.²⁸ The basis for this position has been challenged by Perrow, who argues that the claims made of the accomplishments of therapeutic-community type organizations are without substantial empirical support and, at the very least, inconsistent with knowledge about the functioning of organizations.¹⁸ This need not mean that existing bureaucratic arrangements, such as those in institutional settings and in the developing community mental health centers, represent a necessarily effective and efficient set of arrangements. It may well be, as Ullmann observed in extending Etzioni's views, that staff and line concepts in professional organizations have to be reversed.²⁷ Under these reversed conditions the major treatment activities would tend even more to be carried out by ex-

perts rather than being undertaken by just about anybody, as occurs under what may be called the generic solution of everyone doing everything.³⁰

Besides, even if the concept of equality and sharing of tasks could be accomplished, it represents a temporary solution given the congruence between the world of the practicing profession and that of the business community. Although Whyte's²⁰ analysis of participation in the social structure is certainly not above criticism, it is difficult to deny the relevance of some of his observations regarding the motivations and dispositions of individuals in their occupational roles. Reserved parking spaces if not rugs on the floor, a new dictaphone if not keys to the executive washroom, and travel money to attend conventions if not country club membership are not absent from the bargaining encounters of persons in the field. Like executive training programs, a variety of different types of educational adventures in the health and welfare fields are predicated on producing new leaders, even if we do not know who and what they should be. Students at an undergraduate level in places like Wesleyan University are being trained to be policy-makers; new schools of policy science are in the offing; several of the large systems-oriented planning and development corporations are in the business of human resource curricula development; and some professional schools concerned about their relatively low reputations are turning to innovative leadership programs in order to provide some sort of instant uplifting of their status.

The continued trend toward equality and diffusion of the roles of the various subsets within the consortium of mental

health practitioners, until there is one undividable ball of wax, is a remote possibility. Rather, a better guess is that new groups within the consortium will begin to seize dominance and control, and the field will return once again to a more vertical sorting of individuals and an increased specialization in task allotment. The ideology of American social life as well as the dynamics within the consortium will lead to the gradual assumption of increased power by professions now, or at least in the past, regarded as marginal in status and competency and denied the opportunity to participate fully within the consortium of health professions. As they legitimize their place and tighten requirements to obtain their credentials, they will render the traditionally superordinate groups illegitimate and, like the carpetbaggers of the Civil War era, will first infiltrate high society and then capture it.

Whether such an occurrence is entirely desirable or not cannot be assessed. It depends, in part, of course, on whether the structural influences on the provision of health care services, particularly mental health care services, continue in the same direction as they are currently moving. If not, one may suppose that again some kind of strategy will be used to hold the loosely knit consortium of mental health professions together, until once more there is a restructuring within it.

POSTSCRIPT

A postscript is called for. In developing this paper, the effort, originally, was to look at the problem of future manpower needs in the mental health field. This is not entirely a topic without research, as anyone who has read Albee's¹

volume, or critiques of it, and other studies is aware. In these times, however, to approach the problem of manpower in the mental health field, one must confront the situation that has occupied us in this paper.

The complex links between the social structure, program development, and arrangements within the consortium render impossible, at this time, any estimates or predictions on either the quantity or quality of people required in terms of a table of organization. The question that must be answered is beyond the scope of present knowledge; what one must be concerned with is the issue of the type and nature of inputs required to develop an orderly but flexible set of arrangements within the consortium of mental health professionals in order to respond to the shifting demands of the larger social structure.

Even if he would not agree with our analysis, as Robert Rieff has observed:

The mental health professions' posture is not that of a group of people with a successful product harassed by a clamoring demand, it is more like a group of desperate men struggling to hold back a flood and who cannot find the hole in the dike. This kind of manpower crisis is totally different from the usual shortage, for while it is true more bodies are needed to stem the tide, unless the hole is found and repaired or the water redirected, it will be a losing battle.²⁰

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THE EUROPEAN EDUCATEUR PROGRAM FOR DISTURBED CHILDREN

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Innovative institutional programs for disturbed children have been extensively developed in France, Holland, England, and Denmark. These programs represent a basically different approach than is found in the United States. A key aspect of this work has been the development of a new professional role (educateur) and theoretical model for institutional work with maladjusted children.

The treatment of emotionally and socially maladjusted children in the United States has become a large-scale national problem. These children include the mentally ill, the seriously disturbed, the character disorders, the acting-out aggressives, the unwanted and disadvantaged, the pre-delinquent and delinquent, the socially alienated. Over \$86,000,000 alone is spent annually on institutional care for delinquents. The maladjusted children's problem in this country is one of gross size and character. It is apparent that our traditional approaches to problem children have made little impact on basically lessening the general chaotic conditions which characterize this field.

There are few people in the mental health field who would deny the charge that the problem children's field is centrally marked by the virtual absence of integrated and carefully articulated services on a state and national basis. The traditional professional approach in the children's field in the United States has substantially limited the possibility of developing coherent and meaningful social services for problem children. In contrast, the European approach differs markedly from the more accepted and dominant treatment pattern which characterizes much of the American work.

The treatment model in a large number of our centers may be described in the following manner. There is primary em-

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phasis on diagnosis, casework, and group and individual therapy. The professionals furthest removed from the daily life of the child have the highest status and rewards as well as control over the regimen prescribed for the child, while those individuals with the closest personal contact with the child and his actual behavior have the lowest status and the poorest rewards for their work.

The traditional and preferred treatment model in public schools, children's homes, delinquency institutions, and in most public and private agencies handling maladjusted children has been to emphasize the psychological or pathological component in the children's behavior. Both in practice and theory the American approach stresses the importance of individual psychological understanding. Since the medical model has been the dominant one in this field, the tendency has been for the subordinate disciplines to formulate their treatment approaches in conformity with this model.

While variations of a single treatment model may be dominant and traditional in our national culture, it does not follow that this pattern of treatment is the most effective means of coping with the terrible conditions which routinely exist in the problem children's field. Many of our most pietistic assumptions, as well as our practical procedures, in the children's field are not utilized or accepted in several European countries.

The European approaches are often sharply different from our own. Their operational work with maladjusted children appears to have progressed significantly beyond that in the United States. The central purpose of my study tour of Europe was to examine the newer ap-

proaches used in the handling of disturbed and maladjusted children in institutional settings. From my readings I knew that a new professional role and theoretical model had been developed for institutional care. This paper will primarily concern itself with this new development in the maladjusted children's field.

THE EDUCATEUR PROGRAM

A new professional role has emerged in France, Holland, and Denmark: intensively and broadly trained childcare workers, called "educateurs" in France and "ortho-pedagogues" in Holland. The most advanced work in this field is found in France. The training of the educateurs has been institutionally developed there over a 20-year period. These programs are highly sophisticated in terms of program articulation, personnel selection, public acceptance, and high professional status for the educateurs involved. There are 26 training colleges for educateurs throughout France. Several of these colleges are an integral part of the local university. They provide about three to four thousand educateurs each year for a vast range of institutional placements. The number of training centers is continuously growing, so that the output of graduate educateurs is expected to be doubled in the next five to ten years. There is great institutional demand for the graduate educateur, and the program and profession is generally well accepted in the mental health field in Europe. The educateur training program in France is an independent discipline; it is not a subordinate part of education, social work, or psychology.

The educateur movement had its inception during the Second World War, which produced a large number of ne-

glected and abandoned children. Individual leaders established centers for these children and soon realized the imperative need for trained youth workers to serve as model adults and substitute parents. There had long been a tradition in Europe of training youth workers in pedagogical theory and practical activities to work with young people in their leisure time, so the wartime camps for displaced children began to develop training programs for their youth workers. These courses incorporated a good many of the conceptual and practical ideas which had characterized the pedagogical training models for many years.

It is in this area that a major difference exists between the European concept of *educateur* and the traditional American concept of social worker, teacher, and houseparent. The *educateur* is not a case worker, nor is he specially trained in diagnosing and therapeutically handling the maladjusted child. He is not a teacher who is attempting to instruct the maladjusted child and bring him up to a particular academic level. And finally, he is not a traditional houseparent or ward attendant who attempts in an uninformed way to control the behavior of his wards. He is, rather, a highly trained professional youth worker who is primarily concerned with the total life process of the individuals in his group. He is trained to utilize all the leisure moments of a child's life, to program this free time in a manner that directly engages the child's physical, moral, social, and intellectual development.

The *educateur* concept may be briefly described in the following manner. There is a major emphasis in his training and recruitment on the positive and normative aspects of adult and child behavior. The *educateur* is expected not only to

program the entire daily and weekly life of the child in the institution but to serve in a deliberate and trained manner as an adult model for the child to emulate. In this sense, key stress is placed on a positive total milieu in the institution, in contrast to an atmosphere charged with staff strain, competition, and irrelevant status and power concerns.

In many of the French institutions for maladjusted children, the *educateurs* are the central and dominant figures in the total life space of the children. The services of the teacher, the psychiatrist, the psychologist, and the social worker are important and are utilized; but the management, the programing, and the other major operational aspects of the children's lives are determined by the *educateur-director* and his staff of *educateur-colleagues*.

The concept is simple. The *educateur* is the closest one to the child from the time of rising in the morning to going to bed at night. He is responsible for the child's total behavior, and his involvement with his group is expected to be not only professional but personal in the sense of concern for their daily welfare.

The *educateur* is viewed as the central person in the reeducation and resocialization of the maladjusted child. He lives in the institution and provides a highly structured activity program for all the leisure (nonschool) hours. His main function is to utilize his "model and normative" personality as well as his extensive knowledge of various crafts and physical skills as avenues through which the resocialization of the child can occur. He is equipped in his training to initiate various kinds of physical activities with the malfunctioning child. Through these activities and projects he is able to develop a close rela-

tionship with the child. The activities serve as a bridge of interest and motivation for the child and provide the educateur with an entry point to the child's personal concerns and feelings.

Differing from the more traditional approaches, the relationship between the educateur and the child is not based on a verbal exchange, nor does the educateur impose his psychological understanding or provide interpretation of the child's behavior. The relationship is essentially a therapeutic process based on the child's modeling his behavior on the educateur and gaining insight into behavior through what the educateur does rather than through any planned verbal exchange apart from the actual moment-by-moment life of the child.

The educateur leaders state that their best work is done "in and through" the behavioral life space of the child. Their relationship and therapeutic effect is achieved not by planned intervention, not by therapeutic interviewing apart from the child's life process, but through their extensive physical involvement in the daily moments of the child's life. When the child or the group (usually two educateurs for ten to twelve children) desires information or help with a problem, the educateur, like a parent, is there to provide assistance and understanding. Unlike a parent, however, the educateur is trained to understand and cope with behavioral disorders. He is also trained to provide several kinds of physical activities to directly engage the child's mind and body during times when such activities are relevant.

The careful screening of candidates for educateur training is viewed as of primary importance. Candidates often spend a full week undergoing interviews, tests, observations of interactions with

maladjusted children, and a general evaluation of their potential as effective educateurs. While equivalent educational comparisons are difficult to make, it appears that the beginning French educateur would be comparable to an American junior college graduate.

In France, as in other European countries, restrictive educational policies create a large labor pool from which able new recruits may be drawn for educateur training. The opportunity for becoming an educateur offers a young person in France the chance to enter the professional world with its attendant social and economic rewards. It appears that the educateur's work is one of the few professions that does not involve rigorous academic requirements before entering. Hence, it provides a social and an economic opportunity which would probably not be otherwise available in France.

The actual training program for the educateurs is a three-year course. About 50% of this time is given over to an internship in a range of treatment centers for maladjusted children. These placements are carefully supervised and serve a training and a selection function for each educateur. The different placements provide him with a realistic awareness of the nature of children's problems, and provide the training center with a means of evaluating his competencies and difficulties with various kinds of handicapped children. This makes it easier to eventually place him in the kind of setting which most appropriately fits his talents and interests.

About 25% of the training program is given over to craft and vocational training. Since a good deal of the educateur's time during his internship placement is spent in craft work and in program plan-

ning for his group, his actual training in this area is quite extensive, perhaps as high as 50% of the total program. This activity training should be carefully considered, because this component of the educateur's work is quite different from any work that the author is aware of in similar United States programs for handicapped children.

Theoretically the idea is to reach the child through the activity. The activity is not the goal in itself. It is the means through which the child and the educateur can arrive at shared interests, human understanding, and behavioral modification. Emphasis is placed on the value of the activities both in coping with the problem behavior and in the positive channeling of misdirected energy. The total day and week in the institution is preplanned by the educateur, allowing for the individual interests of the children. This planning assumes that programing and activities are nearly synonymous concepts. A large range of activities during the week offers each boy the opportunity to find an area of positive self-expression. This interest may then be used by the educateur to help the maladjusted child enter more fully into age-appropriate behavior. But this is not achieved through planned intervention in the child's life process, but rather by the physical and emotional involvement the educateur achieves with the child in the various activities.

During the three-year training process the educateurs receive training in several applied activity areas. These often include such diverse skills as ceramics, painting, creative design and layout, home economics, maintenance and interior decoration, wood and metal work, cooking, music, dramatics, puppets and marionettes, choral work, dancing, pho-

tography, and various indoor and outdoor recreational skills. The educateur is expected to have a working acquaintance with several of these areas, and a depth interest and knowledge of at least two craft activities and one athletic interest. The educateur is also taught to utilize entertainment media such as films, plays, television, radio, as well as field trips and camping outings as a means of gaining involvement with his ten or twelve children.

One year of the educateur training sequence is designed with a maximum emphasis on group living. The training staff utilizes guided group interaction and sensitivity training to help the students understand the social-psychological factors involved in individual and group life. Since the students are placed in an institutional setting with maladjusted children for three to six months during their first year of training, they are expected to analyze the group life of the institution in which they are interns. Their own sensitivity training and their institutional placement are deliberately structured to make the two experiences more integrated.

The remaining fourth of their training consists of academic course work, and during their final year, thesis writing. Some of the theoretical material is taken from American research and theory such as that of Redl and Wineman, Bettelheim, Erikson, Zander and Cartwright, Henry Maier, and Rogers. There is also a large body of published literature in the educateur field.

The training colleges for educateurs attempt to give the students a broad understanding of the several areas of handicapped children. This is done through lectures as well as actual placements or visits to the full range of devi-

ant children's programs. In the final year, the students are expected to select an area of special interest like delinquency or retardation in preparation for their entry into that kind of institutional setting.

In France, the educateurs work in and frequently manage institutions for delinquents, retarded, physically handicapped, socially and emotionally disturbed, the homeless, the neglected, unwed mothers, and several other agency settings. They also are trained to function as street workers in slum areas, usually working out of a youth club as a central base.

In Dijon, France I visited at least ten different settings in which educateurs were primarily responsible for the overall management and direction of the centers. They utilized the services of the psychologist, psychiatrist, case workers, and teachers, but the daily management and social responsibility of the institution was in the hands of the educateur-director and his staff of fellow educateurs.

ENGLISH "APPROVED SCHOOLS"

While the central purpose of my study tour of Europe was to examine the educateur and ortho-pedagogue programs, I also managed to visit several other facilities for maladjusted children. In most of these institutions, as well, there were professionally trained counterparts of the educateur. I visited several "approved schools" in England. Approved schools are state-sponsored residential institutions for delinquent children. In these schools, I found an extensive utilization of vocational activities. The Herts Training School in southern England, for instance, has a wide range of activities for its boys—a small farm,

livestock, complete dairying facilities, carpentry and metal shops, a gardening program, a home improvement and interior decoration shop, a cooking laboratory, and a rather complete program designed for the total physical maintenance of the institution. In addition, there is a well-equipped school and very comfortable living and recreation facilities. This emphasis on vocational training has a long history in the English approved schools. In the instances where the programs are integrated with professional understanding of the maladjusted population, some very good results appear to be achieved.

The English approved schools differed in several ways from their American counterparts. Not only is the emphasis on vocational training, often in a very elaborate and advanced form, but also there is general integration in the whole service throughout the country. The English system is highly centralized and coordinated by the Home Office in London. This means that the more than 100 schools are licensed, financed in part, and inspected by the Home Office staff of government inspectors. Through this system it is possible to achieve a rather high standard of school programs, to remedy and improve deficiencies in the system, and to see that the staff and facilities in the institutions are operating at certain agreed upon professional levels. These standards are continuously examined by government commissions of enquiry, and upgrading of the staff and facilities is frequently undertaken. This centralized approach to children's welfare seems to be characteristic of England, France, Holland, and Scandinavia.

The centralization of service also permits less overlapping and competitive

institutional work. It tends to eliminate the deliberate exploitation of people in need of social and psychological assistance because the services are inspected and agreed-upon national standards must be met. Further, the centralization makes it more feasible to provide a range of integrated and differentiated children's services in the areas in which they are requisite. For example, all of England is divided into districts. In each district there are diagnostic centers where the child is carefully examined for a three-month period. Following this evaluation, the child is placed in an institution that is best suited for his particular needs, and a rehabilitation program is designed for him by the institution. In each district there are also detention homes, children's homes, and a range of services including vocational retraining and hospitals for the mentally disabled. While the complete integration of these services is a long way from actual achievement, there is a strong movement in that direction, and some districts already have a series of closely integrated children's and adults' services.

In contrast to European systems most large cities in the United States have a vast and confusing array of overlapping and professionally competitive services. In general, there is no central organizing authority which has the power to coordinate the chaotic maze of poorly integrated children's programs. The county services compete with the city agencies, the private placements with the state agencies, the schools are defensive and self-isolating, while the medical establishment is rarely involved in the planning of integrated community services. Competition and exploitation in the market place is one thing, but in the mental health field another approach is

essential if the major and destructive problems of our cities are to be realistically solved.

England, Holland, Denmark, and Sweden seem to be significantly ahead of the United States in terms of the integration of their mental health facilities. These countries have assumed that mental health services need to be planned on a nationwide basis. They feel that adequate and integrated services and high standards in this field are a requisite condition for the efficient and intelligent operation of a modern state. The United States is unique, as a powerful and successful democratic system, in its fear of national planning in the field of mental health. We are unique in the particular manner in which we rationalize and deceive ourselves about the failure and gross inequities of our national mental health services. There are few professionals in the mental health field who are unaware of the chaos, disorganization and professional exploitation which deeply and tragically scar our work in this field. It is time that we faced up to the reality that much of our work in this area is seriously inadequate.

SUMMARY

Several European countries have extensively developed a new professional role known variously as *educateur* and *ortho-pedagogue*. The role is that of a highly trained child care worker who utilizes craft, vocational, and recreational activities to gain a close personal relationship with a group of from ten to twelve handicapped children.

The traditional professional roles of psychiatrist, caseworker, psychologist, and teacher for maladjusted children remain essentially the same. The psychiatrically-oriented professionals play impor-

tant roles as consultants and individuals therapists where the need is indicated; the social workers see the parents of the children in a traditional casework sense. The difference lies in the fact that the daily management and direction of an institution caring for these children is in the hands of an educateur-director and his staff of educateurs.

The central assumption in much of the European work with handicapped children is that the adult closest to the children is extremely important in their re-education and resocialization. If these adults are important, their selection, training, and status rewards as professionals are also very important. If the child care personnel are viewed as of secondary importance in the institution, their work will not be effective, creative, or productive with their group of children.

The educateurs, or trained youth workers, are used in a wide range of settings. They are used as street workers, club directors, and recreation workers in poverty districts. They are used as directors and workers in the whole range of activities and clubs for normal children and adolescents. Many of the youth and adult centers which have long been established in Denmark, Holland, and Russia have almost no counterpart in American society.

There is a major emphasis in the educateur work on handicrafts, dramatic play, dance, vocational training, and recreational sports and gymnastics. These activities serve a dominant role in the rehabilitation of the child. They provide the child with the possibility of finding an area of social and physical skill in which his self-concept may be directly changed. They also provide the realistic basis for a relationship of trust and ac-

ceptance between the child and his educateur, who works closely with him in these specific activities.

All of the daily moments of the child's life are utilized by the educateur. This means the hours of the day and the week are carefully planned in terms of the needs, interests, and behavioral level of the child. The educateur is expected to be totally involved and responsible for his group of children. His training and selection heavily emphasize this expectation. For this reason, it was common in France to find educateurs spending time in children's homes, finding jobs for them, contacting their teachers, and in many ways providing the follow-through that is rarely found in the United States.

Sensitivity training and applied group dynamics are stressed both in the educateurs' training and in their actual work with the children. Various forms of self-government, group discussion, sociodrama, psycho-drama, and group therapy are commonly practiced in the educateur training courses and in the handicapped children's institutions.

A major difference between the actual children's programs in selected European countries and the United States is the greater practicality, creativity, and flexibility of European programing for handicapped children. The diversity and creativity of individual European programs was tremendously impressive.

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REVIEWS OF THE LITERATURE

FAMILIES OF THE SLUMS

Salvador Minuchin, Braulio Montalvo, Bernard G. Guerney, Jr., Bernice L. Rosman, and Florence Schumer

New York: Basic Books. 1967. 460 pp. \$10

Families of the Slums reports on a group of 12 delinquent-producing families and the effect of family therapy on them.

Adult males are absent or peripheral in these mainly Negro and Puerto Rican families, and the mother is the nominal head. All families have a son at Wiltwyck school for boys (a private residential treatment center for 100 boys, age 8 to 12), where the family therapy project was initiated under an NIMH grant.

Two of the book's chapters present verbatim transcripts from the therapy sessions, the others describe the setting and the strategy of the research, the structure of the families, and the nature and success of treatment used. A long appendix gives us background facts about the families as well as details about the instruments used in studying family interaction: (1) transcripts from therapy sessions, (2) a family task (as, decide on a dinner menu), (3) a Family Interaction Apperception technique (individual responses to cards portraying family scenes).

While the mothers are relaxed about their nurturance function, they are not relaxed about their authority over their children. Parents do not make or enforce uniform rules or offer much guidance to children. Power relations ("Do it because I said so, and I'm the boss!") rather than reason are used to control the behavior of children. In general there is much assertion

of power and vying for position in the family.

Communications are poor. Family members do not expect to be heard and do not listen to others. Spouses rarely talk or relate much to each other. Children talk mainly to mother rather than to each other. Mother scolds and regulates noise, but rarely does she emphasize any positives in the behavior of her children. A common family theme is: the world is dangerous.

The therapists found few clearly defined roles, little regulation, few resources for sustenance in these families. The extended families found were not "collectives," they conclude, in that members rarely offer each other close, positive relations or mutual aid. Even grandmother plays a dubious role in that she tends to take over from the mother and make her more dependent.

Because of the failure of parent authority, a parent child (usually an older son) often takes over much of the family's direction, keeping siblings in line by bullying and ranking. Or, children turn to peers for guidance and authority.

Family therapy consisted largely of helping mothers direct and guide their children better, thus reducing the authority of the parent child and of the peer group. Where fathers or other adult males were present, the therapy attempted to increase their authority and improve relations between spouses.

Among these families were found two polar extremes of authority failure—the disengaged family and the enmeshed family, one having abdicated control over children and the other unable to let any of it go. The therapy in the first case aimed at returning the head of the family to a

guidance and control role, and in the other it was aimed at releasing some of the parents' strong controls and permitting greater autonomy of children. It was found useful in therapy to let parents observe interactions between their children and the therapist or the spouse in order to learn new ways to guide, talk to, and relate to their children. The enmeshed mother was helped to see that her children were overdependent rather than rebellious, and the disengaged mother to see that her children would respond to adult guidance.

Seven of the 12 families improved to some degree as a result of therapy. They increased their capacity to explore alternate ways of coping with family stress, moved away from extreme disengagement or enmeshment, or found a greater range of emotional expression, more acceptance of parental roles, better spouse relations, more effective parent control and guidance.

The authors suggest it may be the general powerlessness of the poor that makes it difficult for them to properly exercise family authority. They also suggest that members of many poor families cannot respond to changes in the "opportunity structure"—cannot take advantage of job training and placement, education, etc.—until their distressed families are treated and made healthier. Undoubtedly this is true. Therapy is no substitute for a healthy society, equal opportunity, jobs, higher income—but it certainly can be helpful until the real thing comes along—and even after, as relations among some people, even in the happiest settings, inevitably break down. It is one thing to complain about the "failure of the Negro family" as a way of letting ourselves off the hook for creating that family, but it is quite another thing to make an honest effort to reach out beyond the failing child to the failing family, to understand it, work with it, help it learn to function better and more autonomously. Insofar as Dr. Minuchin and his associates have given us new insights into the delinquent family and found some successful techniques for treating its distress, their book was worth writing and is worth reading.

Beyond some thick language (perhaps

the professional's own "failure of communication"), the only criticism I would offer has to do with the title *Families of the Slums* and with the erroneous implication that all, most, or even many slum families are as disordered as these 12 delinquent ones. The inappropriateness of the title is especially striking in view of the authors' more positive findings about 10 similar but nondelinquent families used as controls. We will never get where we're going if we assume that "slum families" generally need treatment before they can take their place in society.

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PSYCHOLOGY IN COMMUNITY SETTINGS

Seymour B. Sarason, Murray Levine, I. Ira Goldberg, Dennis L. Cherlin, and Edward M. Bennett
New York: John Wiley & Sons. 1967. 714 pp.
\$12.95

This is a book for school psychologists by clinical psychologists. It describes how the Yale Psycho-Educational Clinic approached the New Haven school system and found ways of serving the schools. By implication, it shows any school system's staff of psychologists how they might work effectively as clinicians in the school setting.

Beyond this, the book is a detailed model of how a group of clinical psychologists can cooperate with an agency of local government in serving the inner-city population as part of a program of social urban renewal. They tell their story in the first person plural, rather simply, without claiming to do more than apply their special knowledge and skill in a commonsense way to the needs of children and youth in a city. There is no claim to expansion of our understanding of human behavior. Rather, their intention is to show how existing knowledge can be put to good use by a school system and by an anti-poverty agency through cooperation with service-oriented clinical psychologists.

The first twelve chapters are devoted to the ways in which the Psycho-Educational Clinic put itself at the service of the school system through consultation with teachers and treatment of children in the clinics. These chapters are full of case reports illustrating the procedures used.

Another section of the book deals with the service given by the clinic to Community Progress, Inc., the pioneer urban renewal agency of New Haven, and its neighborhood employment centers. There are descriptions of service given to disadvantaged young people in need of vocational and educational guidance. A substantial report is given of the summer work programs for out-of-school youth aged 16-21. This includes a systematic report of "A Day in the Work-Crew Life of Willie P" (a 17-year-old Negro boy), modeled on Roger Barker's *One Boy's Day* and giving the same kind of matter-of-fact nonjudgmental detail.

The final section describes the New Haven Regional Center for Mental Retardation, as seen from the Psycho-Educational Clinic. The center was just being developed as this book was written, and consequently only the opening chapter of its life is reflected here. Both the Regional Center and Community Progress, Inc. were created to serve the city, with little or no tradition or preorganized structure. Their relation to the Psycho-Educational Clinic was therefore quite different from the clinic's relation to the established and bureaucratized school system.

This book is full of useful illustrations of ways by which clinical psychologists can cooperate with schools and anti-poverty agencies. As is noted in the Introduction, this is a prologue to a research program of major importance which will occupy the clinic in the coming years. This program will seek to answer two questions: How do we understand and describe the school settings? and, How do we introduce change into an ongoing social system? The leaders of the Psycho-Educational Clinic believe that they can answer these questions only after they learn much more about the contemporary community. For this they think

the mental health worker must join forces with the anthropologist and the sociologist.

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NEUROPSYCHIATRY IN WORLD WAR II

Robert S. Anderson, Albert J. Glass, and Robert J. Bernucci, Eds.

Washington, D.C.: Office of the Surgeon General,
Department of the Army. 1966. 826 pp. \$7.50

It is one of the supreme ironies of human history that important advances in some of mankind's most constructive activities—science and medicine—so often occur in the course of its most destructive activity—war. This phenomenon is documented once more in this long-delayed massive report on psychiatry in the U.S. Army in World War II (Zone of the Interior). As stated in the Foreword, "Military psychiatry gained immeasurably from the experiences of World War II. . . . Perhaps even greater gains were made by civilian psychiatry as evidenced by its explosive expansion following World War II."

An earlier effort to write this report failed because of the assumption that "such a history could be written with part-time leadership." The effort was revived in 1956 with new administrative and editorial leadership and enlisted the help of several hundred World War II psychiatrists in providing the raw material. The actual chapters were written by approximately 70 authors who had been in military service during the war and include a number of leading figures in American psychiatry.

This first volume covers such topics as Professional Personnel, The Consultant System, Selection and Induction, Hospitalization and Disposition, Hospitals, The Mental Hygiene Consultation System, Preventive Psychiatry, The Women's Army Corps, Forensic Military Psychiatry, Psychiatry in the Army Correctional System, Neurology, Clinical Psychology, Psychiatric Social Work, The Neuropsychiatric

Nurse, Occupational Therapy, Reconditioning of Patients, and The Chaplain. The chapters are replete with relevant official documents, reports, charts, graphs, and bibliographies, but retain in the main a refreshingly simple, readable narrative style.

The individual authors were given freedom to express their viewpoints and this is evident in the frankness with which abuses and injustices are detailed, administrative conflicts and contradictory policies are documented, and the frequent hostile attitude of regular army personnel to the psychiatric service are cited. Also in evidence is the devotion and dedication displayed by the psychiatrists and other professional workers, together with some key members of the army hierarchy, in bringing the best possible medical care to the American soldier in spite of the obstacles. To this reviewer, who lived through many of these struggles as an army psychiatrist in World War II, the report does indeed ring true. It can be recommended highly as a definitive document.

One specific point appears worthy of special comment. Both the Foreword and the Summary emphasize how much the current movement and concepts of community and social psychiatry can be considered "as a highly logical extension of the insights achieved by military psychiatry in World War II." It is true, as the volume documents, that the experiences of that war demonstrated conclusively the decisive importance of the current life situation in the production of psychiatric disturbances. Variations in such factors as intensity and duration of external stress, living conditions, climate, and the nature of the social environment produced striking differences in psychiatric outcome. Military psychiatry in World War II also demonstrated that "emotional illness was most effectively treated when such treatment was accomplished as soon as possible and as near as possible to the site of origin." However, "the explosive expansion" of American psychiatry immediately following World War II *did not* take a community and social direction. On the contrary, it focused on the influence of early life experience, considered that unconscious intrapsychic

states formed early in life were all-important in the individual's psychological functioning, and established as the preferential mode of treatment one which created an artificial social environment in the psychotherapist's office and which bore no relationship to the patient's real-life environment. It is only in the past few years that this direction has been altered to emphasize social and community psychiatry. It would therefore appear that "the insights achieved by military psychiatry in World War II" were lost upon most psychiatrists and are only now being discovered anew.

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A GUIDE TO READING PIAGET

Molly Brearley and Elizabeth Hitchfield

New York: Schocken Books. 1967. 184 pp. \$4.50

A Guide to Reading Piaget is a book to help practicing teachers understand Piaget's work on intellectual development in children. The authors approach their objective through the presentation of excerpts from seven major works of Piaget and his associates, organizing them according to such basic concepts in the Piagetian system as conservation, correspondence and equivalence, measurement of length and distance, perspective, horizontal and vertical coordinates, physical causality, and moral judgment.

Methods of the original investigations in each instance are succinctly described. Representative protocols delineating the various stages are quoted verbatim from Piaget as are certain of his interpretations. Of particular interest to the practical-minded are brief comments by the two authors at the end of each section regarding the teacher's role in utilizing the findings of Piaget. These comments emphasize, for example, the importance of helping children consolidate active, concrete experiences in order for the construction of mental operations to occur and for the ability to understand and evaluate causal relationships to develop.

This book is especially commendable in the light of what Flavell² described as an underassimilation of Piaget's brilliant and

remarkable contributions to a theory of cognition. It is true that such underassimilation has been corrected, in part, in the realm of psychology where an impressive number of studies and books have emerged in the last several years. The growing output ranges from reports of conferences devoted to the work of Piaget (Kessen and Kuhlman⁴) and accounts of the man himself and his productivity (Baldwin¹) to a long list of actual studies replicating and extending some of the original experimentation of the Genevan school. In contrast, at the present time curriculum development and classroom teaching strategies with only a few exceptions, notably Ripple and Rockcastle,⁵ have failed to take note of the importance of the Piagetian evidence pertaining to the development of intelligence and the implications for learning.

The simplicity and brevity of Brearley and Hitchfield's guide should be fruitful in providing teachers with a less formidable introduction to a study of Piaget than would a first reading of almost any of his original works. I hope, however, that once exposed, teachers will pursue further the primary sources since much of the essence and excitement of Piaget's observations and conclusions tend to be lost in any synoptic account. In fact, in many ways the beginning student experiences and comes to comprehend the main theses in Piaget only by having to grapple himself with the complicated and unfamiliar concepts which make up the extensive developmental scheme. Such a student learns that, as Piaget suggests, knowledge is not merely a copy of reality. To know an object or event comes about as a consequence of modifying it, transforming it, and understanding the process of this transformation, and finally being able to interiorize the action which then modifies the knowledge of the object.

The authors have successfully demonstrated their knowledge of Piagetian methodology and have made basic transformations of it for the benefit of the classroom teacher of young children. The book could be a landmark in a fresh examination of what Hunt³ terms the match that is needed

between inner cognitive organization of the child at each level and the appropriate encounters offered by the school, encounters which could maximize the child's present stage of intellectual functioning and help develop it further.

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THE ADOLESCENT GIRL IN CONFLICT

Gisela Konopka

Englewood Cliffs, N. J.: Prentice-Hall 1966. 177 pp.

Gisela Konopka's little volume, *The Adolescent Girl in Conflict*, merits the thoughtful attention and respect of the mental health professions. It is a courageous, creative effort to explore a little-known social phenomenon, to analyze her findings about the tragic life histories and institutional experiences of these young girls both in their own terms of feelings and values and in terms of cultural change and attitudinal patterns in social institutions, and from this analysis to essay new stances which might transform "correctional" institutions into "rehabilitative" ones.

Dr. Konopka brings to this study long productive experience as a social worker, teacher, and theorist, a breadth of knowledge of literature, philosophy, and the social sciences, and personal qualities of in-

sight, compassion, and wisdom. It is refreshing to read a research report written with conviction and an honest sharing of the creative process of theoretical formulation.

Konopka's study population included 181 adolescents between 14-19 years of age, 100 from delinquent institutions for girls, 76 from three "homes" for unwed mothers, the remainder clients of a Big Sister agency in Minnesota. Her review of related literature points out a variety of theories of delinquency growing out of studies of boys, and the paucity of theory about the delinquency of girls.

Konopka was "convinced that much research into understanding of human beings has been hampered rather than advanced by a limited approach dictated by a preconceived theory." Hence she eschewed fixed hypotheses and cultivated an open-minded attitude of exploration. She "had a hunch that better understanding would accrue out of a better view of the cultural conflict in which the girl finds herself." Konopka is an experienced social worker and relied on her interviewing competence as her major tool in research. She added depth by adapting the methods of anthropological field work of "living with" the research group, sharing daily routines, gaining the confidence of her informants by her genuine, warm interest in listening to what the girls spontaneously expressed in unstructured interviews and group discussions. Data was recorded by tape or as nearly as possible by verbatim recording.

For this exploratory study Konopka used no checklists or questionnaires and spent no energy trying to develop research instruments. She does not report conventional clinical diagnostic studies or tabulations of sociodemographic data or an evaluation of the methods and efficacy of interviewing or group therapy. Instead she devoted her intellectual efforts to seeking new understanding and articulating it in an "emerging" theoretical framework. She brooded over the passionate, intense confidences entrusted to her, using her intuitive and informed insight to follow clues and identify strong indications of personal and cultural influences. She asked ques-

tions of herself and her colleagues and sifted out and pondered the meaning of these vital segments of life experience and feeling against the background of the culture of poverty, the changing role and status of women, and the policies of institutions. The style of her research report was dictated in part by her conviction that these girls need to be heard in their own voices, and by her faith in this kind of search for new understanding.

Noting that "we have not yet a language which expresses an integration of the whole personality as part of his human relationship and the total culture surrounding it," Konopka presents her analysis in terms of key concepts of psychological and cultural factors, documented by numerous excerpts from interviews, case summaries, and poems and essays written by the girls. She traces a linked chain of circumstances and reactions which enmesh the girl in increasingly serious, frustrating, self-defeating and asocial behavior. This chain is presented diagrammatically as a scheme of theory, which is illuminating and rich in potentials for further research.

This theoretical analysis provides a basis for suggestions for practical and far-reaching changes in social services and institutional management. Her conclusions and recommendations should challenge individual workers and administrators to an honest appraisal of their attitudes and policies and to creative efforts to change the spirit as well as the methods of their services. For mental health workers in other fields, her study will deepen our realization of the suffering behind the resistance or bravado of delinquent girls and the inextricable duality of deprivation from both the family and the culture bind.

Konopka's research was supported by a three year grant from NIMH and by the University of Minnesota. It is encouraging to find support given for exploratory research of this nature. Too few of those with mature experience and skill devote time to a systematic analysis of a group of case studies or discipline themselves to the difficult venture of articulating their nascent insights into a framework of complexly interrelated concepts. Konopka's

example should encourage others to undertake creative research.

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SCHOOL DISORDER, INTELLIGENCE AND SOCIAL CLASS

Mary Alice White and June Charry, Eds.

New York: Teachers College Press, 1966. 92 pp.
\$2.25

PSYCHOLOGICAL CONSULTATION IN THE SCHOOLS

Ruth G. Newman

New York: Basic Books, 1967. 300 pp. \$6.95

Riots, rape, and radicals make the headlines in today's press. Behind the headlines there is another story. The story of innumerable attempts to rethink, revise, innovate, and question school functioning. The two books reviewed here are concerned with two school research efforts—one statistical, fact-finding, "tough-minded"; the other, action-oriented and "tender-minded." Both have something to say to the practitioner and the theoretician.

School Disorder, Intelligence and Social Class started as a project in an experimental school psychology class (an innovation in itself), then burgeoned into a full-fledged field study with respectable subject population, specified outcomes, and provocative implications. *Psychological Consultation in the Schools* provides sharp contrast with its emphasis on the feelings and needs of teachers and students.

Of the two books, *School Disorder, Intelligence and Social Class* will likely have the greater impact, since the questions it raises apply not only to school problems but to some of the basic theoretical structures in the field of psychology and mental health. "School disorder" in the study was defined as a "term that best described a variety of judged maladjustments in school culture which are applied to children. The term, as used here, includes learning difficulties, social difficulties, emotional dis-

turbances, deviant or antisocial behavior, or any combination of these." This study attempted to establish (1) that there is a positive relationship between school disorder and later mental disorder and (2) that the variables of adult mental disorder apply similarly to school disorder.

To investigate their hypotheses, the authors and their students gathered data on over 2,000 children who had been referred for service to the school psychologists of Westchester County, New York. Children in Westchester County schools come from homes that are considerably above average at the professional and managerial levels and below average in the clerical and sales, operatives, and service workers areas of the socioeconomic (SES) scale. Such a sample population will, of course, affect the findings of the study. The reviewer wonders what results would be obtained from a low rather than high socioeconomic population.

Another source of bias is that the findings are based upon the characteristics of children who have been referred to a school psychologist for service. Individuals who work in and with schools know that the criteria by which children are referred for service varies considerably from school system to school system and from state to state. In some settings, school psychologists may work only with children who may be eligible for classes for the retarded while potential referrals for emotional problems are immediately shunted off to local agencies or to other school mental health personnel such as social workers or special teachers. In other settings, children with perceptual disorders provide the bulk of the school psychologist's workload. One needs constantly to be aware that the findings of this study are biased not only by the social composition of the school, and state and local policy, but also by other differential criteria.

Perception of services available to the public and to teachers may also bias the results. In this study, the school staff referred about 75% of the cases while 18% of the cases were referred by parents. The number of parent referrals seems to constitute an unusually high percentage of the total workload of the psychologist. If pa-

rental referrals reflect only close parent-teacher cooperation, then one might not be too concerned. Data provided in the study, however, indicate that there is considerable difference between the type of child referred by parents and the type referred by school personnel. Parents tended to refer children who were intellectually more capable, achieving at a higher level, and of higher socioeconomic status than children referred by teachers. It is interesting to note that the mean IQ of children referred by parents was about 110.5, which is considerably above the 101 IQ levels of children referred by other sources. Only school personnel can appreciate the trauma created in an upper socioeconomic, college-oriented family by children who are intellectually capable of "only average work" in schools filled with very bright, high-achieving youth. In such schools, parents of average children frequently flock to the school psychologist for help. Of course, a child referred by such a parent will be quite different from the child referred by a teacher because the child deviates from the norm provided by a large group of children. Such differences in referrals, of course, affect the outcomes of the study, but only in that they lead to some provocative ideas rather than by providing any rationale for ignoring the findings.

Any attempt to review the many findings in a limited space would do the authors an injustice and deprive the reader of the opportunity to be challenged by the content. Several of the interpretations of their findings, however, do warrant comment. Such comment will help provide insight into the difficulties encountered and types of results that occur.

At one point, the authors state that, "Perhaps, surprisingly, withdrawn behavior is a referral label applied more often to boys than to girls." These findings are somewhat less striking if one places them in the context of the research that shows that boys deviate more from the mean on most dimensions, including IQ, height, and weight, than do girls. These findings, then, serve to remind us to continue to be aware of boys' tendencies to be at the extreme.

Another one of the findings is that there is a relationship between both IQ and SES and the type of psychological service provided. That is, children of higher IQ and SES receive the more complex psychological services. Such a finding is not necessarily unexpected, yet we frequently fail to realize the total effect of such a practice. When we bring into focus the problems of self-fulfilling hypotheses and diagnoses based on SES (which include the factor of availability of parents for interview), it becomes obvious that the "chain of actions" for a child who gets only a limited intellectual assessment will be different from the "chain of action" for the child who has a complex evaluation. One interesting outcome is that "brain-damaged" children tend to be of higher SES than "culturally deprived," while other research suggests that brain injury is found more frequently in lower SES families.

In the final summary, the authors state, "It is possible to arrive at two quite different interpretations of our findings. The first is that the pupils who are selected as mentally ill, and who receive most of the mental health services, are those who are less likely to become mentally ill adults. It appears that we are treating the potentially healthy pupils with psychotherapy while the potentially sicker ones are treated with educational methods. If so, then there needs to be a careful reevaluation of the pupil population served by the mental agencies. The children perhaps most in need of these mental health services are also the pupils with the greatest learning problems in school. The second interpretation could be that . . . the significant aspect is the importance of *learning*. The prime problem facing these children who may later become adult mental patients is a learning problem."

The contrast between *Psychological Consultation in the Schools* and the *School Disorder* study is quite striking. Basically, Ruth Newman, with some help from Claire Bloomberg, has prepared a selected anecdotal type record of the trials and tribulations of a "psycho-education consultant." They report on their work as consultants to a school in a status or role that is not

too carefully delineated. The few guidelines that are provided state that this method is psychodynamic and interdisciplinary, flexible, and centered on the relationships of consultant to staff members, to staff members and the children they serve, and to the school that employs them. Consulting is viewed as continuous and regular rather than crisis-oriented, as based on continuing relationships and familiarity which lead to trust. Small group work is considered to be the most desirable mode of practice, although one-to-one contacts are occasionally necessary.

The authors describe, through an anecdotal format, the problems, mistakes, and types of cases they faced in each of several schools. To provide broad coverage, examples and anecdotes are presented from an elementary, junior high, senior high, residential, and cooperative nursery school. The descriptions of activities tend to be factual and objective, hence they will help the beginning student become sensitive to the problems and pitfalls that they will likely meet in a school setting.

Probably the greatest deficiency in their approach derives from their emphasis on attacking the problems of children by using only an emotionally disturbed or mental illness point of view. It might have been much more helpful if the authors had been able to give more consideration to "learning" types of preventive or remedial activities. Information available to personnel working in the schools or discussed in books such as the preceding should raise frequent questions about the importance of providing academic as compared with emotional types of assistance to children.

In summary, readers are encouraged to read *School Disorder, Intelligence and Social Class* for some refreshing restatements and challenges to the appropriateness of some of our present practices. *Psychological Consultation in the Schools* is recommended to the newcomer to consultation in the schools as a source of descriptions of the problems and activities that they will face along with a few sug-

gestions that may keep them out of difficulty.

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SCHIZOPHRENICS IN THE COMMUNITY—An Experimental Study in the Prevention of Hospitalization

Benjamin Pasamanick, Frank R. Scarpitti, and Simon Dinitz, with the collaboration of Joseph Albini and Mark Leffon

New York: Appleton-Century-Crofts. 1967. 448 pp. \$8.00

A decade or so ago, a popular author produced several volumes formulating directions for helping Johnny to read, Ronnie to write, and Dickie to speak. I have long forgotten most of his prescriptions, but one stays with me. This was an appropriate introspective consideration to be utilized when the reader or auditor is faced with advertising, propaganda, or even scientific publications. The consideration has two parts: (1) "Specify!" and (2) "So what?"

The book by Dr. Pasamanick and his collaborators has been in print for some months, so other reviewers have dealt at length with its specifications. Without question, the study was well-designed and well-organized; the research approach was deliberative and rigorous; and the written result was comprehensive and thought-provoking. Some reviewers have carped about details of methodology, but my impression was that the authors demonstrated very clearly in a well-controlled investigation that many schizophrenic patients—when supported by appropriate drug therapy and regular follow-up care by public health nurses—can be treated as well or better at home than in a mental hospital (and this in the face of prior similar studies reporting opposite or equivocal results). For this work, the authors were awarded the Hofheimer Prize for Research at the 1967 annual meeting of the American Psychiatric Association.

At this point, then, the "so what?" looms large. Abundant data from a variety of sources indicate that there are a great many persons suffering from psychiatric disorder resident in our American communities, whether such persons live in Baltimore, midtown Manhattan, or Williamson County, Tennessee. Other data from other sources (including this present work) indicate that a great many of these persons—be they neurotic, depressed, schizophrenic, aged, or simply facing a family crisis—may be successfully treated out of the hospital. But should they? Many of us have believed that one good reason for avoiding hospitalization is that home care is much less expensive than hospital care, and it is a shock to read in this volume that "home care programs . . . are not likely to be very much less expensive than intensive hospitalization" and that "community mental health centers featuring comprehensive, coordinated, and continuous services will surely be very much more expensive."

Expensive or not, mental health services in the community are frequently regarded by professionals in the field as more effective and of greater scope than hospitalization, and such mental health professionals are likely to regard hospitalization for mental illness as an archaic approach. Most such professionals agree that there are many therapeutic advantages in treating patients outside of the hospital whenever possible, and also agree that the traditional massive custodial mental hospitals have been marked by inadequate and even inhumane treatment of their patients. The dignity of the individual patient and the concept of active treatment and cure often have been ignored in such institutions.

Since World War II, however, smaller open ward hospitals (often affiliated with general medical hospitals) have demonstrated their value. With the advent of new emphasis on psychodynamic and learning theories, individual and group psychotherapy techniques, flexible partial hospitalization and aftercare procedures, open door and therapeutic community programs, and the use of the newer psychotropic drugs, short-term hospitalization with the goal and expectation of returning patients to useful functioning in the family and the

community is still very helpful to the clinician dealing with the great variety of psychiatric patients. There will also be with us for many years a relatively smaller number of patients who require continuing or repetitive supervised long-term institutionalization, and certainly new innovations in dealing with such persons are necessary. The clusters of attractive, cottage-type units pioneered in the Scandinavian countries might be a starting point.

Thus, the "so what?" of this book is both simple and profound. Clearly many quite ill patients can be treated effectively at home but—equally clearly—flexibility and a number of approaches are still mandatory. The community mental health center movement, with its emphasis on the multidisciplinary provision of a variety of clinical and consultative services, is a giant step in the right direction. *Schizophrenics in the Community* demonstrates another important advance. And, as John Locke wrote almost three centuries ago, "Every step the mind takes in its progress toward knowledge makes some discovery, which is not only new, but the best, too, for the time at least."

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TRIUMPH IN A WHITE SUBURB

Reginald G. Damerell

New York: William Morrow & Co. 1968. 351 pp.

It is an old cliché that truth is often more exciting than fiction. This seems to apply to *Triumph in a White Suburb* because it is an historical narrative that reads much like fiction. Of course, it represents the author's perceptions of history. But one becomes immediately aware that these perceptions are not capricious. They seem extremely well founded and are obviously based on endless hours of research and study. But the book reads much like a novel, or as someone else commented, more like a detective story.

If it is a correct prediction that by the

year 2000 90% of the population of this country will reside in communities of 20,000 or more, then Mr. Damerell has given us a preview and some guidelines to use during the lead-in time by creating a document that gives an account of what might be the prototype or microcosm situation facing fast-growing and sprawling suburbia. Suburbia, of course, is going to face an urban set of conditions. The flight to the suburbs is unceasing. *Triumph in a White Suburb*, which deals with the suburban "all-American" town of Teaneck, New Jersey, could be the story of any of those suburban municipalities on the periphery of any of the large metropolitan centers from which dormitory suburban commuters derive their living and sustenance.

The movement of people into Teaneck from the large metropolitan areas of New York follows a classic sociological pattern. The otherwise white Anglo-Saxon Protestant suburb first resisted the in-migration of the Jewish population of the large urban center. Then that population, now somewhat ensconced and able to establish some sense of collective identity, bands together in an attempt to stop the in-migration of the Negro. But the Negro was also able to move into the community, albeit in a ghettoized fashion.

Mr. Damerell, who is meticulous, draws a very careful picture. He begins at the onset of the Negro migration into Teaneck and carries through to the creation of a central school plan to increase equality in education. The major issue was a popular vote of confidence in the election of three school board members who were for a centralized school as the vehicle for elimination of the racially imbalanced schools that served the ghetto in the town. This reviewer is a resident of Teaneck. He lived through the last part of the struggle to establish the centralized school. He watched the defeat of an active and vocal neighborhood school association and saw the election into office, by an overwhelming majority, of a slate of candidates committed to deal with some of the moral questions of equal opportunity in the public schools of Teaneck. His knowledge of the facts in-

dicates that Mr. Damerell is an accurate and precise reporter indeed.

Beyond that, Mr. Damerell is also an astute layman having profound knowledge of the makeup and operation of society. He weaves together an excellent narrative by using the best insights of sociology and psychology to make telling points about the particular postures of the groups in opposition within the community. For example, he quotes a sociologist on the "immorality" of the practices of real estate men, and illustrates this behavior in Teaneck by describing their actual activities—block-busting, scare-tactic selling, an outright unabashed statement signed by a group of realtors purporting that if the neighborhood schools were to go, the property values of Teaneck would drop. (It should be mentioned, by the way, that the neighborhood school as such has gone, the property values of Teaneck have not decreased but have increased, and the desirability of buying a house in that community from all present indications seems to be on the rise rather than on the decline.)

Mr. Damerell is aware also of the nature of prejudice. He uses some of the findings of the classic studies and applies them appropriately in context. His applications are most trenchant. The narrowed perceptions occasioned by the prejudiced mind are boldly etched as Mr. Damerell recounts the story of the white couple looking for a home in the now fast-becoming Negro section. A relative of the white owner showed a white couple the home and reported later that day that "an extremely light-skinned Negro couple" had looked at the home. So narrow were the perceptions, Mr. Damerell indicates, so intense was the prejudice, that the individuals selling the home, even though face to face with the white couple, could only conceive of them as Negroes if they were to buy a home in this area. "That a white can see a Negro because that is what he expects illustrates the emotional difficulty most whites have with regard to Negroes. They can see them when they are not there," is the author's comment.

But if one thing becomes clear in the text of Mr. Damerell's message, it is the

idea that these times demand quality leadership if any activity is going to involve the people in a moral and meaningful way concerning these problems. There was leadership in Teaneck, and those leaders are the heroes in this book. Actually there are three heroes. The Town of Teaneck is one, the other two are individuals. The mayor of the community, the first Jewish mayor, is the political hero. The other man is the superintendent of schools. Both moved the community and their respective followers toward commitment and decision.

Within the book itself one sees several profiles of courage. One is that of the first Negro, James Payne, who bought a building lot in 1953 in an area that "should" have remained an undeveloped and continuous buffer to the growing Negro community of the adjacent town. The strength of James Payne as one who wanted to have a decent place to live and one who had every right to live decently, is always encouraging. It makes everyone mindful of his own inadequacies when faced with the terrible issues of hate. The profile of a school board which was tentative at the start but grew to become a forceful advocate of integration is an interesting one. Two minority members of the board and their insidious backers portrayed for the majority in bold relief what the alternatives were. The board's growth is also an indication of what can happen when insight into the problems becomes real. The growth of a mayor whose obvious aspirations went beyond the mayoralty of that

community, but yet was willing to stand on the line for a very unpopular issue, is an interesting political portrait. The growth of the "unaware Christian" as to what the moral realities of such a situation were, was a source of insight. And finally, the growth of that large block of voters and workers who marched relentlessly to the polls to create the triumph stands as an attestation to what can be done if people of good heart and intellectual awareness band together to address the egregious and unhappy circumstances that have for too long divided this land. But in the final analysis, one can see that it was the leadership and the commitment of the superintendent of schools that moved the community to action.

This book then is a text. It is a handbook. It has all the qualities of a "how-to" book about the manner in which one can achieve school integration in communities that are plagued by the problem of racial imbalance in their schools—imbalance brought about by the ghettoization of Negro minorities within their midst. The hope is, of course, that if open housing and various other opportunities can be created, so second-class citizenship can be abated. This may be long in coming. But until that time, communities need definitely to move in the area of school integration to reconnect the schools with the public they serve.

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MENTAL HEALTH HIGHLIGHTS

by Jack Wiener

Center for Studies of Mental Health and Social Problems, Applied Research Branch
National Institute of Mental Health, Chevy Chase, Maryland

Better Than You Think

Although 1968 was a troubled year, some significant gains were made in Federal legislation related to mental health. And there were some losses. Altogether though there were more plus than minus signs.

HANDICAPPED CHILDREN'S EARLY EDUCATION ASSISTANCE ACT (P.L. 90-538). The Office of Education is authorized to make grants to public or private nonprofit organizations for experimental programs of education and counseling for handicapped children under 6 years old. In addition to the physically handicapped, mentally retarded and emotionally disturbed children are included. Services may encourage the "intellectual, physical, mental, social, and language development" of these children. The participation of parents is urged.

The Federal contribution may go up to 90% of costs, and evaluation of each program is required. For fiscal year ending June 30, 1969, \$1 million is authorized for planning. When operations should be underway, \$10 million is authorized for fiscal year 1970 and \$12 million for fiscal year 1971.

ALCOHOLIC AND NARCOTIC ADDICT REHABILITATION AMENDMENTS OF 1968 (P.L. 90-574). The major result of this law is to give special attention to services for alcoholics and drug addicts within the Federal program for construction and staffing of community mental health centers.

In the alcoholism provisions, the law ex-

plicitly says that Congress wants chronic alcoholism to be treated as a health problem rather than as a crime. Grants may be made in an area that does not have a community mental health center, if "provision has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of alcoholism."

In regard to drug addiction, the 1968 law takes the place of a more liberal section of the Narcotic Addict Rehabilitation Act of 1966. Narcotic addict services are now tied to community mental health centers, except for training and evaluation.

For both the alcoholism and narcotic addict programs, the same non-Federal matching is required as in the community mental health centers program, which is already resulting in financial difficulties for some localities.

To carry out the law, \$15 million was authorized for fiscal year ending June 30, 1969, and \$25 million for fiscal year 1970.

JUVENILE DELINQUENCY PREVENTION AND CONTROL ACT OF 1968 (P.L. 90-445). A new Federal program to deal with juvenile delinquency was created—a larger program than ever before. Federal grants will go to states, local, public, and private nonprofit groups for planning, preventive and rehabilitation services, demonstration projects, construction of facilities, and training of personnel in fields concerned with juvenile delinquency.

"Preventive services" include educational programs in local schools and services for

youth on probation and parole. "Rehabilitation services" cover the improvement of diagnosis, treatment, and rehabilitation provided by law enforcement agencies and innovative services such as community residential centers for youth, or halfway houses.

A comprehensive state plan is required, as well as state matching. The law emphasizes community-based services and the coordination of community agencies working with juvenile delinquents.

The Secretary of Health, Education and Welfare is responsible for carrying out the law. In fiscal year ending June 30, 1969, \$25 million is authorized, \$50 million in fiscal year 1970, and \$75 million in 1971. The Federal share of the costs varies with the different programs in the law.

HEALTH MANPOWER ACT OF 1968 (P.L. 90-490). Federal support for the training of medical and allied health personnel is extended and expanded. The special training programs in nursing and public health are continued. Each professional school is to receive a small annual institutional grant. Financial incentives are provided for a school to increase the number of students that it enrolls and graduates. Also, student loans and scholarships are provided.

Last, I must at least mention the far-reaching **HOUSING AND URBAN DEVELOPMENT ACT OF 1968 (P.L. 90-448)** which forbids racial discrimination in the sale or rental of most of the nation's housing and provides Federal aid to help low-income families buy or rent decent housing. And, also, you should know about the **HIGHER EDUCATION AMENDMENTS OF 1968 (P.L. 90-575)**, particularly for its large authorization of funds for higher education and for its programs to make it possible for more students from poverty areas to continue their education beyond high school.

In Washington, the big, ubiquitous problem is the money crunch. A Congress intent on economy made sharp cuts in appropriations. As this is being written, it is uncertain which programs, old or new,

will be reduced. How much money is made available from appropriations will determine to what extent the new programs promised in legislation become a reality.

I want to acknowledge the current and past aid and counsel on legislative items in this section which I have received from Mrs. Rollee Lowenstein and the staff of the Legislative Services Branch, National Institute of Mental Health.

Counties Front and Center

Across the country there's been relatively little success in fitting state mental hospitals together with local community mental health programs. Often, communities have rid themselves of mental patients by simply sending them away to the state hospital.

A 1968 law passed in California pioneers a promising attack on this problem through amendments to the state's comprehensive community mental health services law (Assembly Bill 1454). A new method of financing public mental health services is established, with the county paying 10% and the state paying 90% of costs whether the service is provided by the local public mental health agency or by the state mental hospital. Thus, counties will pay for 10% of the costs of county residents in the state hospitals. The law tries to eliminate the financial incentive for localities to send patients to state facilities instead of using local resources. Annual county mental health plans must include the use of state hospital services, and a county-designated agency will screen and refer patients before they are admitted to a state hospital. Much closer working relationships between local and state facilities should result.

Most of the mentally ill and alcoholics are covered by the new law, but there are some exceptions such as the mentally retarded, drug addicts and mentally disordered criminals.

The new law goes into effect on July 1, 1969—at the same time as the new liberal **Lanterman-Petris-Short Act**, which severely limits the use of involuntary hospitalization of patients. What happens in California is worth watching.

Sex

Most professionals in the human service fields probably have not had enough training about sexual development and sexual problems. So it's encouraging to learn that the University of Pennsylvania School of Medicine is establishing a new national center to help medical schools train doctors to deal more effectively with the sexual difficulties of their patients. The new Center for the Study of Sex Education in Medicine is headed by Dr. Harold I. Lief, a psychiatrist.

Also, New York University's School of Education will begin the nation's first master's degree program in health education which has a special emphasis on sex education.

Siecus Newsletter 3(5):3 and 4, June 1968 and 4(1):4, October 1968.

I Want My Mommy

A new study of young children admitted to hospitals confirms the belief that it is important for mothers to stay with their children in the hospital. In Birmingham, England, when plans were being made for tonsillectomies or adenoidectomies of children under 6 years of age, their mothers were asked if they would be willing to accompany their children into the hospital for a three-day period if a bed was available. About one-fifth of the mothers said that they would be willing to stay in the hospital. From this group, an experimental group was set up of 101 mothers who actually did spend the time in the hospital with their children. A control group of 96 mothers were told that it was not possible to arrange for them to remain in the hospital. On a range of social and psychological factors, there were no significant differences found between the two groups before hospitalization.

But, in the hospital and after discharge from the hospital, the children who had been accompanied by their mothers in the hospital showed much less emotional disturbances than the control group. Outside the hospital, emotional disturbances included such problems as sleeping difficulties, clinging behavior, temper tantrums,

etc. In the control group (where mothers did not stay in the hospital) the youngest children, those from 2 to 4 years old, showed the greatest maladjustments. Most surprising, the children in the control group had more postoperative infections.

At the end of the study, 85% of the mothers who went into the hospital said that they would go again if their child was admitted to a hospital.

But all the nursing staff on the ward said they preferred that children be admitted without their mothers. Hospitals, of course, must have nurses. If parent-child units in hospitals are to become more common, enlisting the support of nurses is essential.

D. J. BRAIN AND INGA MACLAY. *Controlled Study of Mothers and Children in Hospital*. *British Medical Journal*, 5587:278-280, 3 February 1968.

New Cure for Hysteria

According to the *Washington Post*, at the August political convention in Chicago, Allen Ginsberg, the beat poet, and his followers distributed a leaflet which said the following:

"In case of hysteria solitary or communal, the magic password is AUM—the same as OM—which cuts through all emergency illusions. Pronounce AUM from the middle of the body, diaphragm or solar plexus. Ten people humming AUM can calm down one hundred. One hundred people humming AUM can regulate the metabolism of a thousand. A thousand bodies vibrating AUM can immobilize an entire downtown Chicago street full of scared humans, uniformed or naked."

Comes the Revolution?

A 1965 study of the mental health professional personnel involved in treating mental illness in the Chicago metropolitan area found relatively little overlap or "role blurring" in the functions performed by each professional group. Of a total of 1,052 psychiatrists, clinical psychologists, and psychiatric social workers identified in the community, 70% returned the ques-

tionnaires—a very good response. Of the respondents, 41% were psychiatrists (including psychoanalysts), 33% were clinical psychologists, and 26% were psychiatric social workers. The major job activity of the large majority of the psychiatrists was therapy, as contrasted with about one-fifth of clinical psychologists and psychiatric social workers. However, an additional one-fourth of the psychologists and social workers said that their major job activity was "counseling/casework." Of the three professions, clinical psychologists were most engaged in teaching and research, while administration was the largest single activity for social workers.

More than half of the total group, including all professions, had a psychoanalytic ideology. Only one in seven believed in a "social/community" approach.

About one-third of the mental health professionals, primarily psychiatrists, were in private practice providing therapy. The next most frequent types of work setting were psychiatric institutions and educational institutions (universities, professional

schools, etc.) Most professionals working in psychiatric institutions or agencies were primarily engaged in administration, rather than in treatment.

The Chicago findings present a familiar picture of the traditional use of professional mental health manpower. We don't know whether there has been much change in the last few years. Further, similar studies are underway in Los Angeles and New York City, but the findings are not yet ready. So, it's too early to say whether the Chicago data are typical.

S. LEE SPRAY. *Mental Health Professions and the Division of Labor in a Metropolitan Community. Psychiatry* 31(1):51-60, February, 1968.

Down with Up

According to Anna Freud, youth are losing interest in psychoanalysis. "They see that what psychoanalysis may lead to is adaptation to society. That's the last thing they have in mind."

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I certify that the statements made by me above are correct and complete.

(Signed) Pauline B. Sherman
Business Manager

LETTERS TO THE EDITOR

(continued from page 2)

As we took steps of progress to separate the child from the adult offender and to provide a court process in keeping with the nature of childhood, did we really not know what other resources would be required? Did we provide adequate settings geared to their needs as children? Did we provide, as we now are contemplating, social health and correctional services for these children? Should we have been surprised at the fact that an increasing number of these juvenile offenders were children who have lost hope, in the belief that no one really cares, and are children whose historical roots were already deeply imbedded in the deprived, neglected, and angry environment from which they came? Should we really have been surprised at their mask of indifference or their ostensible inability to learn from previous errors?

As the field of pediatrics, through the phenomenal advances that had been made, became able to turn its attention to that of well baby and child care, the everyday problems of child growth and development, the parental concerns of child-rearing, did we provide the pediatricians with the necessary knowledge, skill, and resources for them to truly assume responsibility for the psychosocial aspects of medical care? Should we have been surprised at the fact that children with congenital defects can produce parental feelings of anxiety, anger, guilt and shame; that children with chronic disabilities which require long-term care and management can decrease the coping capacity of the family; that children who are ill may require psychological buffering to aid them in coping with their own illness or disease; that children require more than adults with equivalent disease or illness? Did we provide then the gamut of resources to aid the pediatrician in this task?

As our schools were faced with providing an education for a substantial increase in the child population, did we truly prepare for this task? Did we know the conse-

quences of our inadequacies? Should we have been surprised at the results? Did we then provide the resources necessary, and resources we now are moving to provide in the form of social work services, guidance counsellors, remedial education, special classrooms, better health care, psychiatric consultation, seminars for teachers, increase in salaries for teachers, facilities geared to need?

And finally, as our nation awoke to the serious state of emergency in regard to mental illness and the state of mental health of our society, did we begin our initial effort with children? As all of you know, we did not. Our first major step in this new direction, in 1955, focused attention on the adult, and from these findings a Joint Commission evolved legislation for the mammoth task of providing comprehensive mental and retardation health centers. Having achieved this, our society 10 years later has *only now* undertaken a three-year study of children through a Joint Commission. Did we not know then the sad state of unpreparedness of our society insofar as children's services were concerned?

In my less paranoid and angry state, I do not believe that organized society is anti-children. However, it would seem that our adult society continues to believe that since they are only children they will outgrow their problems, that problems in children cannot really have long-term consequences, and therefore we can temporize with what is required.

The point to be made by this review of our past is simply this—that in taking those steps necessary for implementation of our Comprehensive Mental Health and Retardation Law, we must remember that our temporization in the past has produced a comparative void in children's services from whence we must begin. A void which now we have an opportunity of filling. If there is any lesson to be learned from our past it is clear that we no longer can afford to temporize with the requirements for child health, education, and welfare. We no longer can afford to simply speak of disturbed children or retarded children as if they really can be separated from all

other children. Our new law, aided by yet other laws, will enable us to state clearly that we are interested in all children, in the care of children, and in the events of living which produce children with behavioral symptoms, whether such symptoms arrive from brain damage, retardation, deprivation or psychopathology. In brief, we are interested in providing the services and manpower now needed to prevent, identify, diagnose, and treat the behavioral symptoms of children and at the same time those services needed for the promotion of their health, including that of mental health.

Children make up approximately 30% to 40% of our population. Of this group of children, we are concerned with those who live in poverty, with poverty defined as a place in which is bred the three- or four-generation disease of social deprivation, lack of sensory stimulation, hopelessness, and symptoms of physical and psychological disease. Of this group of children, we are concerned with those born with congenital defects, who are now able to survive but in surviving are to live with physical handicaps and problems of rehabilitation, all of which can bring with them the emotional drainage of a family. Of this group of children, we are concerned with those born with brain damage, related to poor prenatal care but bringing with it psychological problems which may interfere with the constructive rehabilitation of the child. Of this group of children, we are concerned with those in need of long-term care and rehabilitation as a result of chronic disabilities brought about by neurological disorders, cystic fibrosis, rheumatoid arthritis, diabetes, and other chronically disabling diseases—disabilities which will also bring with them psychological symptoms. Of this group of children, we are concerned with those under the age of 5 who will die as a result of accidents, but accidents which can be related to the child rearing atmosphere—the child who takes poison which should have been out of reach, the child who is left unguarded in a hazardous area, the child who is beaten. Of this group of children, we are concerned with those in foster homes, ostensibly for neglect but with a high pro-

portion of these children showing behavioral symptoms. Of this group of children, we are concerned with those children in need of recreational outlets, specialized tutoring, vocational guidance, parental support. Of this group of children, we are concerned with those children requiring a head start or a new start or a creative start. Of this group of children, we are concerned with those requiring some form of psychological help which we are not currently able to give. We are concerned with the fact that despite a decrease in the adult mental hospital population, projections for the decade of 1963–1973 show that there will be an increase in the number of children admitted to mental hospitals.

To further bring home the point of sobering facts, it should be recalled that: in many of our states, and under existing mental health and retardation laws, children's services cannot develop or expand towards a comprehensive center unless they are affiliated with an adult service; it is the rare community which by comparison to adult services can provide at this point in time *all* of the required elements of service for children to be called comprehensive; as yet, children in need are seriously mismatched to the service available or offered, and children are managed, housed, and cared for in facilities not geared to their need; past limited resources in funds, staff, and interest have produced among the limited available resources for children a state of horrible competition, fragmentation, diffusion.

Despite the current interest of our society in children, and the current support for them, there will be a considerable lag in time before all of our counties can provide a substantially greater measure of comprehensive services for children. The task ahead is a sobering one. The goal will not be achieved easily, cheaply, or without problems. Again, it must be emphasized that for children we are starting from a point of comparative void, and it must be remembered that *our new law simply provides us with an opportunity*. For those of us in the childrens' field, we must begin our task of implementation with what we have,

and from where we are, but we must *continue to ask* our adult society "What's In It for Children?"

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Non-This and Para-That

TO THE EDITOR:

In discussing the people lately added to those who have traditionally worked in the mental health field, a speaker is likely to refer to "the *nonprofessionals, nontraditional professionals, paraprofessionals, or whatever-you-want-to-call-them.*" This semantic hedging gives voice to our discomfort at our failure to grant acceptance and status to this group of crucial helpers. As long as people are called *non-this* or *para-that*, the exclusionist label reflects our failure to grant them recognition. It is high time that we began to use a title for these important workers that has positive connotations, one that expresses its holder's role not by what he is not but by what he is.

I should like to suggest that we introduce and use the terms:

- Primary Level Mental Health Worker
- Secondary Level Mental Health Worker
- Professional Level Mental Health Worker

The Primary Level could include the so-called lay person who has a continual occupation in the mental health field, such as the foster parent for emotionally disturbed children, the student who works with patients in a mental hospital, the "indigenous" staff working with community mental health centers, and others who did not receive explicit institutionalized training for their mental health work.

The Secondary Level could include those who received explicit training for mental health employment but whose training did not lead to a master's degree. The bachelor level welfare worker, the teacher-counselor, the child care worker, and the case aide would exemplify personnel at that level.

The title Professional Level Mental

Health Worker could be reserved for those whose occupational specialty has become recognized as a profession and who have been admitted to this profession by an established process. These workers would usually have at least a master's degree in their field and be eligible for membership in their respective national professional organization.

It seems to me that this terminology has much to recommend it. The three levels give expression to the "career ladder" notion that implies that an individual, with additional training, can move from the primary, through the secondary, to the professional level. It further reflects the fact that the worker at the Primary Level is at the "front line" of the mental health effort, that he is the one who is most directly and continuously in contact with those whom mental health work is intended to help. It suggests an open system by virtue of the fact that an occupational group at the Secondary Level can advance to the Professional Level once it becomes an identifiable profession, having developed explicit training programs as well as minimal standards of practice and a code of ethics that is enforced by a national organization. And it reserves the term "professional" to those groups whose occupation society recognizes as a profession, making it unnecessary to expand the connotation to the point of defining it out of existence. I would much prefer to see career channels opened so that people can aspire to and reach the level of a profession than to open the definition so that everyone is a professional by semantic fiat.

Lastly, it would seem to be much easier for someone to declare with pride, "I am a Primary Level Mental Health Worker" than to say "I am a Nonprofessional."

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Action vs. More Research

TO THE EDITOR:

In reply to the letter from Helen Man-

dlebaum and David Phillips in the July 1968 issue, it is hard to believe that two social workers in 1968 would recommend "volunteers" to meet the needs of the poor in social agencies comparable to the medical profession's model. The poor do not want charity. As Senator McCarthy said in the *New York Times*, August 15, 1968, "To give charity does not satisfy the basic needs of *any* people." (Our emphasis.)

That social workers have rationalized their inaction, Dr. Deschin has clearly and unequivocally pointed out. She has explained the theoretical basis for a program of action that will overcome the present ineffective tools being used by social workers to deal with the problems confronting individuals and society.

To suggest that "while there is nothing wrong with theoretical clarity per se, these are times that call for action," shows a total lack of understanding and purpose of scholarly research that precedes action. The difference between a scientific approach and problem-solving by trial and error is the action that is based on theories that have been verified and proven.

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YOUTH IN TRANSITION

TASKS OF ADOLESCENCE

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Adolescence is interpreted as an opportunity for psychological development after puberty which may or may not occur. Modern concepts of adolescence have emerged only in this century, and are related directly to the changes in opportunities for education, increased economic productivity, and changed social attitudes found in advanced industrial nations. These changes have extended to larger and larger numbers of young men and women the opportunity for a "protected" phase of post-puberty development during which greater autonomy, self-regulation, and ethicality become possible. Such psychological growth, which may or may not occur, must be distinguished from biological maturation, which is universal, and from socialization to adult roles, which is also virtually universal. Psychological development, in contrast, is far more problematical, and requires social facilitation and challenge if it is to occur.

A normative view of "adolescence at its best" is presented. This view emphasizes structural (intrapsychic) changes involving an extension of rationality, the humanization of conscience, the integration of impulse, and the re-synthesis of the self. These changes occur through interpersonal and intrapsychic processes that in early adolescence are focused around issues of emancipation from the childhood family and the childhood self, and around issues of dependency and independence. In later adolescence, questions of identity and relatedness to the sociohistorical opportunities that presently exist come to the forefront. For increasing numbers, adolescence or a postadolescent phase of continuing psychological growth may continue well past the teens and into the twenties.

When adolescent development is not foreclosed or derailed, it tends to produce a capacity for adult commitment—to a self that is worth being, to a task, to others and to the next generation, and to invigorating play.

The central problem for adolescents in modern America is that so many are still deprived of the opportunities and societal supports for that unfolding of psychological development which can occur during this stage of life. Too often, therapeutic intervention during adolescence seeks to foreshorten or end adolescence, rather than to capitalize upon it. While some of the foreshortening of adolescence is the result of adolescent ambivalence, even more results from the failures of the adult world. Inadequate familial understanding and support, educational institutions that reward conformity and acquiescence instead of challenge and independence,

unjust social institutions that deprive important minorities of equal rights and opportunities—all conspire to derail or prevent real psychological growth.

American society must move toward guaranteeing to its youth the right of an adolescence. Our society is one of the few with the resources necessary to this task. Historically, a real adolescence has been the privilege of a small minority. We must commit ourselves to making it a birthright for all Americans.

THE SUPEREGO AND THE ZEITGEIST

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The sugerego is defined and some genetic hypotheses are sketched. Social change and conflict is considered as an effect of superego rules, and the effect of social change and conflict on superego tone, effectiveness, and direction is considered as well. Attitude changes are distinguished from superego changes and changes of expression from changes of what is expressed.

Consideration is given to opulence and permissiveness as well as to hedonistic secularization as factors affecting superego contents and style. The attitudes producing social conflict are related to superego factors in both the authority-bearers and in those inclined to defy them.

Chiliastic eudaemonism is related to superego aggression and defense.

CHARACTEROLOGICAL PROBLEMS IN TODAY'S ADOLESCENT

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Are we witnessing an alteration of values? Are our ethics changing? What is acceptable behavior? Currently, we are constantly being made aware of widespread ferment in all areas of life as people seek to exist in the modern world with its potential for material comfort and for devastation. The resulting dissonance requires modification of established pathways to conflict resolution. It is the thesis of the authors that youth is most sensitive to the vagaries of this adaptive struggle.

Since the moral and judgmental basis of existence emanates from the established social order, the young must experience the presence of its authority if they are to fulfill their role as bridge builders to the future.

Case illustrations are used to show how in contemporary society the adolescent's struggle with authority can take one of three forms: He can reject it, live with it, or change it. The question of pathology along any of these coping styles depends not

so much on the nature of the struggle with authority as it does on the varying perceptions of meaningfulness as defined by contemporaries.

Probably the greatest number of youth, even those who present themselves for psychiatric help, follow the second of the stated alternatives, that is they attempt to accommodate themselves to the existing order. Is pathology the outcome of a failure in accommodation to well-established precedents or is it the inability to "do your own thing"? Observation would lead us to believe that the youth who turn away from and the youth who try to influence their community of origin are subject to the same definition of pathology.

Much has been said about the primarily rebellious nature of the conflict which characterizes the breakaway adolescent. Recent opportunities for experiential encounters in social, political, economic, and religious arenas have again brought into focus the latent capacity of youth to modify authority or its associated values. In connection with this shift in emphasis are changes in the expression of disordered behavior. Whereas the model of an earlier time was the youth who fought his parents' dearly held but ambivalently practiced ideology, the current prototype of rebellious offspring is the youth who denounces his parents' lackluster ideology and pragmatic approach to living. His protestations are conveyed through public shaming of parents or other surrogates of authority in the hope of achieving reform.

The older generation's conflicted pressuring for early maturation along traditional lines contributes to the realization of youth that they are being given covert signals to correct for sensed but denied imperfections. Problems arise as the demands upon the self, which must match and compensate for real or implied deficits in parents, fall short of being realized. Disillusionment over these efforts may lead some to escape the struggle and others to assume the burden of a self-disciplined idealism. These observations support the concept that character formation is a resultant function of the unresolved problems of the preceding generations and of the exigencies of the times.

ADOLESCENT-ADULT IDENTIFICATION AND IMPLICATIONS FOR CHANGE IN SOCIAL INSTITUTIONS AFFECTING ADOLESCENTS

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In the concern over the alienation of today's youth, too little emphasis seems to be placed on the role of extrafamilial and broad societal influences in shaping adolescent-adult identification. This paper looks at that question. It is based on research which included a self-image instrument that evolved out of the writer's clinical and research experience.

The paper analyzes two studies: One involved depth interviews in New York City's social hygiene clinics with 600 teenagers, 12-19, from predominantly urban Negro and Puerto Rican families and interviews in the homes of 100 of their

parents. In addition to problems of VD and illegitimate parenthood, these youth had school and employment problems and were educationally and culturally impoverished on the whole. The other study involved a depth questionnaire administered in school to all the high school juniors of an affluent suburban community. Depth interviews were conducted with a 5% sample of the resident families. Except for a small proportion of Negro and Italian families, a majority came from middle- and upper-income predominantly Jewish families.

In comparing the findings of these two studies, significant differences and similarities by social class emerged. Many of the urban adolescents reflected positive identification with their parents but rejected adult society in general because of their experiences in school and job hunting and their awareness of the discrimination to which they and their families were subjected. Positive identification with parents was confirmed by the proportion agreeing to have their parents interviewed and by the response of two-thirds that they would go to their parents if in trouble. While this finding may seem contradictory, it is interpreted to mean that the adolescents were well aware of the powerlessness of their parents, even though this undermined the adolescents' implementation of parental values. In the suburban study, a majority of the adolescents rejected the materialistic, status-seeking values of the adults, including their parents (though by no means all parents), but their identification with parents and adult society was equivocal. This is interpreted to mean that they reject but are dependent upon the very materialism and status-seeking they decry. Illustrations of the findings will be included in the paper.

Other significant differences by social class were reflected in responses to questions about antisocial behavior. In the teenage VD study, these questions were asked and answered directly and frankly. In the suburban community self-portrait study, there was reluctance on the part of the volunteer interviewers to obtain any admission regarding antisocial behavior either from parents or adolescents. These questions were put in the form of asking what the person would do if he or she witnessed a variety of antisocial actions on the part of peers. The responses inevitably reflected the adolescents' own views regarding their behavior, as well as familial and societal breakdown in ethics and values. The cheating question proved to be highly significant.

Both groups indicated a need for meaningful, socially useful work, irrespective of remuneration or financial need, but in ways differentiated by class and ethnic background. The suburban adolescents were able to articulate their need to transcend the "homogenization" and "pleasure seeking" of their community in the open-ended question regarding the most meaningful experience of their lives, to which 40% did not reply.

A major obstacle to healthy adolescent-adult identification for both groups seems to be the lack of what Erikson describes as the opportunity to be "a small partner in a big world" at an early age. To obtain significant and reliable data regarding this identification requires that researchers have confidence that adolescents can communicate in this personal way, that researchers have a frame of reference that fuses a clinical and sociological approach. The sociological approach clarifies ob-

stacles in achievement of self-identity but a clinical approach is required to clarify problems of those who have achieved little or no discernible adult identification, identifying instead with no one or with themselves and reflecting self-derogation and alienation. The self-image data provide significant insight into the character of the adult identification should be used more frequently. Adult identification was found more positive than is generally realized. Such identification is dynamic and related to an adolescent *at a given period of time*. The need to reexamine child-rearing institutions (home, school, religion, the mass media) for their lag in helping youth to understand and participate in society in accordance with their growing capacities and potential cannot be emphasized enough, especially in light of the increase in adolescents projected for 1970 and 1975.

THE TRANSITIONAL CRISES OF YOUTH AS REFLECTED IN THE HIPPIE MOVEMENT

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A major interest of the Cedars-Sinai Department of Child Psychiatry is the study of families and individuals during major transitions. In recent months, as part of this interest, the author and several other staff members met informally two or three times a week for three months with a group of approximately 30 hippies living in communal fashion in a home in Los Angeles. Some of our clinical impressions and related psychosocial factors are taken up in this paper: (1) A comparison of the quality of rebellion presently seen among the hippie group with the rebellion of adolescents as seen throughout the ages. (2) Does the hippie movement reflect a broader sociocultural crisis, including major changes in family life and social values? (3) Can one assess the state of psychopathology before, after, and during drug usage? (4) What subcultural groups comprise the hippie movement? (5) What is the meaning of the religious/mystical aspects of some hippie groups?

The paper particularly attends to major psychological and social adaptational stresses of young people during transitional crises, and the use of LSD and marijuana as an attempt to handle such stresses. Some of the major adolescent work which seems unfortunately postponed and only temporarily handled by drugs involve *intimacy, identity struggles, independence-dependence, peer acceptance, integration of rage, sexual identity*.

Although the hippie group proclaimed a great desire for group intimacy between individuals, I was impressed with the lack of any sustained intimacy over any length of time. I observed many quick, fleeting, intense intimate situations when these youngsters were under the influence of marijuana or LSD. However, once off the drug there was a return to isolation; a return to the vacant stare; a return to withdrawal and apparent lack of perception of other human beings' communication. They seemed to want to avoid the slow evolution of intimacy with all its ambivalence

and pain, the ambivalence and pain over possessiveness, the ambivalence and pain over identity loss in an intimate relationship, the ambivalence and pain over rejection. There was a tendency to experiment with sexual intimacy with many people, apparently to avoid overinvolvement and loss of self in any one relationship.

There was a striking need among these youngsters to repress all feelings of *anger* and to resist recognizing verbal or nonverbal evidence for their anger. There was a fantastic mass denial of any type of angry feelings. Their emphasis on "love," their very "cult of love," was in the service of keeping their anger repressed. One had the impression in their interactions with authority in the Establishment outside that as long as they could project their own feelings of hate onto the outside, nonhippie world, they could continue to repress their own inner rage. One of the songs a 21-year-old young man frequently sang was, "I don't want to walk the roads of anger!" We wondered if the LSD experience unleashed such potential for id expression in these youngsters that a mass group denial was necessary to buffer any potential for such id expression. As an alternative, one might speculate, however, that these particular youngsters had a greater problem with rage than those in a more normal adolescent group, even prior to the utilization of LSD. This remains an open question for further exploration.

The last part of the paper deals with current social and family changes, the question of hypocrisy and the generation gap—and how both of these are related to poor resolution of the conflicts of youth and young adults. The described observations of these young people in their living environment—outside of hospital and clinic situations—offers us potential insight into the healthy as well as the maladaptive motives behind their dropout way of life.

HIPPIES AS THE FOCUS OF VIOLENCE; OR, DISAFFECTED SOCIETY AND ITS STAND AGAINST YOUTH

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Less than one year ago any accurate reading of the life style of either individual hippies or hippie tribes would have had to describe them as relatively nonpolitical, passively alienated human beings whose nonaggressive rituals generally consisted of pelting passersby with flowers as one manifestation of their chaotic but peaceful response to a chaotic and often violent world. Subsequently, and at first subtly, the tenor of hippie behavior has become increasingly militant, drawing toward itself as inevitably the flame does the moth the violence their carefully planned encapsulation had hoped to escape.

At first inadvertently provocative, they progressed to a somewhat self-conscious level of put-on until now, finally, a new brand of militantly aggressive hippie has been *forced* to emerge from the flames of busts, and busted heads, at Tompkins

Square Park, Columbia, Chicago, wherever. What is astonishing is that they, with the appropriate aid of the Establishment's ignorance and insensitivity, have brought many others along with them. It is this transition—some would call it revolution—from an attempt at a withdrawn peacefulness which was both antithetical and frightening to the larger, older society to the ultimate "decision" to match stridency with stridency, violence with violence, that has most visibly marked the past 12 months or so. It is the objective of this paper to place this transition into its proper perspective.

Accordingly, four points may be summarized: (1) The apparently hostile reaction toward hippie behavior came not only from the dominant, status quo culture but from minority group members as well and in particular. (2) The avowed and bragged-about passivity and helplessness of the hippie enraged the violence surrounded citizen who found it easy to succumb to "an ethnocentric inability to understand the behavior of different groups. . . ." (3) Because the hippies were readily identifiable, they became an easy target for the police and certain other disaffected segments of society. (4) The media's attempts to confuse and contaminate the roles of victim and executioner have resulted in the contention that somehow, when hippies get beat up and bloodied, somehow it is *their* fault for being attacked.

Emphasis is placed, then, on the very real social-psychological nature of the interdependency between the goads to violence and the unique and specific role of the aggressed upon, and the ultimate and perhaps inevitable congruency of the two in late mid-twentieth century America.

DRUG USE AND INTERPERSONAL RELATIONS AMONG HIPPIES

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This paper is the report of a pilot study conducted on 50 hippies residing in New York's East Village area. The data arising from this study are related to data collected by an underground hippie newspaper during a nationwide survey. These data together with preliminary findings from a current large-scale study of hippies are summarized and related to some general suggestions regarding the etiology and concomitants of alienation found among hippies.

The objectives of the pilot study were (1) to test the feasibility of collecting personal data from members of the hippie community, using structured interviews; (2) to obtain an objective picture of the hippie community in terms of both its members and its social structure.

Data were collected using five hippie interviewers trained in the use of a highly structured interview schedule developed specifically for this project. All five interviewers were college graduates; moreover, two had received advanced degrees and one had attended graduate school. In order to elicit full cooperation, each interviewee was paid five dollars upon completion of the interview.

The interview schedules were sufficiently structured to permit the immediate translation of responses into objective form. Despite the availability of the objective data arising from these interviews, the nature of the study, particularly the small sample size, precludes the generalization of findings to the universe of hippies. Thus, the results of this pilot study may be taken as representative only of those responding to the interview, although suggestive of relationships which deserve further study.

The study suggests that the hippie movement is primarily a symptom of alienation. That is, most hippies in the group studied could be characterized as alienated, removed from, or uncommitted to the dominant values of society. This may stem from and be rationalized by disenchantment with both the prior home environment (i.e., poor familial and primary group relationships) and a perceived discrepancy between society's ethical tradition and its currently valued activities.

Many of those studied had exhibited behavior now considered hippie well before the term had been coined. For example, many reported leaving home in their teens, using various drugs at an early age, being uncommitted to anything or anybody—and having had a feeling of personal irrelevancy in relation to the norms and values of the dominant society.

It is clear that although many hippies espouse the tenets of the hippie philosophy, some have used the movement as a cover for other less utopian forms of behavior, e.g., sexual promiscuity and drug use.

No comparison group was developed in this pilot study, hence no information is available in terms of possible differences between hippies and nonhippiness. Such a research project is currently in progress, under the direction of the author, and should lead to an identification of such variables as would be useful in identifying possible latent converts and the means for early intervention, where warranted.

CHICAGO YIPPIE CONVENTION, 1968: SOCIOCULTURAL, DRUG USE, AND PSYCHOLOGICAL PATTERNS

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The authors are developing techniques for field study of drug-using populations. The visit of the Yippies to Chicago during the 1968 Democratic National Convention offered us an opportunity to test an epidemiologic instrument and to explore a method for gaining a high degree of cooperation from a drug-using population in completion of a self-administered questionnaire.

The instrument was constructed to assess (1) demographic background, (2) current living patterns, (3) political activities and arrests, (4) drug use, and (5) intra-

psychic functioning. The questionnaire (Dope-O-Scope) included new and adapted sections from other instruments designed by us for the Illinois Drug Abuse Programs previously field tested on heroin addicts. Additional sections were taken from validated inventories constructed by the first author for testing college students. In consultation with the editorial staff of *The Seed* (the major underground newspaper in Chicago) the questionnaire was translated into current argot to increase cooperation of Yippie respondents. To encourage true reporting and to protect anonymity, no identifying data were required. 432 questionnaires were completed on a random sample basis. At least one of the authors supervised testing at each session. Cooperation was very good, with a 90% response.

From the Dope-O-Scope tabulations the tested Yippie group may be described as follows: About 99% were Caucasian. Mean age was 20.7 years (range, 13-46). 72% were males. 16% of the males had been in the armed services. Only 59% professed a religion. 53% completed one year or more of college. 34% reported standing in the top 10% of their high school class. 60% were Illinois residents.

The majority resided in metropolitan or suburban areas (78%). Relatively high family mobility was indicated. Parents tended to be of high educational and economic levels (38% of fathers, 28% of mothers held college or higher graduate degrees; 40% of parents had annual incomes of more than \$15,000). Religious affiliations of parents were considerably higher than the respondents' (88% of fathers, 96% of mothers). 43% reported a foreign language, in addition to English, spoken at home in their childhood. Only 68% of families were intact during the subjects' high school years (one or both parents deceased, 16%; separated or divorced, 16%).

Present living arrangements of the subjects were as follows: 36% lived with parents, 28% with friends, and only 7% alone. 7% were married and 7% had "soul mates." During the last year 34% had been students. 47% had worked between 6 and 12 months, and only 12% had not held a job. The major source of support in the past month was a job for 47% of the subjects, and money from parents and relatives for 24%. 60% reported incomes of \$200 or less for the past month; the rest had higher incomes. 12% reported incomes of \$500 and more.

A sizeable proportion of respondents reported participation in various protest activities. Arrests for such activities were relatively rare. Instances of actual reported time served in prison were remarkably few.

Current drug use on a weekly or more frequent basis was as follows: marijuana 82%, hashish 45%, alcohol 37%, LSD 32%, amphetamines 27%, methedrine (speed) 15%, mescaline 13%, and heroin 4% (on a daily basis 1%). The majority of subjects (68%) had used drugs between 1-4 years. The first drug used on a regular basis was most frequently marijuana 85%, amphetamines 6%, psychedelics 5%.

Analysis of the responses in the final test section indicated marked social alienation; a lack of confidence in the socioeconomic, political, and moral structure of society; a generally pessimistic outlook on life and the future; and an increased trend toward self-destructive preoccupation. There was a predominance of ex-

pressed opinions of parents being permissive and supportive in contrast to the essentially negative feelings about society and its institutions. This may provide some important clues to the conflicts felt by youths brought up in affluent, highly educated, permissive families when they are confronted with the less permissive social structures of our college, legal, military, and industrial systems.

ADOLESCENT DRUG ABUSE, PARENT-ADOLESCENT RELATIONSHIPS, AND SOCIAL INTERACTIONS: AN EXPLORATORY STUDY

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This paper is an empirical study of the psychological, social, and epidemiological factors related to adolescent drug abuse. It aims at the delineation of some of the characteristic family patterns, interpersonal relationships, and social situations precipitating adolescent drug abuse. The study has no a priori conception or predetermined hypothesis. It is merely an attempt to discover and isolate factors that may be related to the widespread cases of drug abuse among adolescents. The determination and isolation of such variables may have heuristic value in leading, hopefully, to the establishment of dynamically derived hypotheses and an experimental attempt toward verification of these hypotheses.

Method:

A. Setting: McAuley Neuropsychiatric Institute is an acute emergency residential psychiatric service for the City and County of San Francisco for children and adolescents up to age 18. The Institute's location is adjacent to the Haight-Ashbury district.

B. Subjects: The subjects in this study consist of two groups: one experimental and one control. The experimental group consists of 50 adolescents hospitalized for drug abuse at McAuley Neuropsychiatric Institute for various periods of time during a two-year period from January 1966 to January 1968. The control group consists of 50 randomly selected cases of adolescents hospitalized at McAuley during the same interval for conditions other than drug abuse.

Exhaustive data was collected on these subjects by a team of psychiatrists, psychologists, social workers, and nurses on the staff of the Institute. The data was then coded into a total of 102 empirically derived categories which covered such areas as family patterns and interactions, peer relationships, school adjustment, self-concept, and perceptions of the subject's current life conditions.

Results: The data will be subjected to correlational analysis in an attempt to obtain statistically significant differences between the two groups.

Discussion: This section of the final paper will address itself to the significance of the research findings.

THE ADOLESCENT SEXUAL REVOLUTION: A REFLECTION OF SOCIO-CULTURAL AND FAMILIAL CONFLICTS OVER IDENTITY AND INTIMACY

Frank S. Williams

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The adolescent sexual revolution reflects certain trends in sociocultural and familial forces related to identity and intimacy. This "revolution"—or "evolution"—presents itself in many ways: younger adolescent girls (15–17) involved in extensive sexual experimentation, including intercourse; an increase in overt homosexual experiences among older adolescent boys and young men (16–22); an increased freedom in verbal and physical expressions of sexuality, including nudity.

This paper analyzes certain sociocultural and familial forces affecting these changing sexual patterns and trends, describing too the complexities of these changing patterns. The forces considered include: (1) sociocultural double-bind communications regarding sex and intimacy; (2) familial and social stress on ego-identity at the expense of experiences with human intimacy; (3) the changing role of womanhood in relation to more assertive expression of rights to sexual gratification and experimentation.

Our *society and culture* today present a double-bind communication about sexuality and intimacy. Although our movies and plays encourage freer physical intimacy, very little training of youngsters in the area of real empathy and real mutuality—major ingredients for intimate involvement and communication—is encouraged during the oedipal, latency, and early adolescent years. Instead, the sociocultural as well as familial emphasis in growing up has been upon reinforcing an ego identity based upon achievement, performance, grades, shining in group activities. A competitive, narcissistic type of ego identity is stressed. A child has very little further experience with real intimacy following the initial mother-child symbiosis. He or she is suddenly, at age 18, expected to dip back into that early intimacy experience with mother, to somehow know how to apply that experience to late adolescent love relations.

A similar lack of experience with further intimacies has occurred within changing *family dynamics* during the past 30 to 50 years. Instead of one-to-one meaningful interactions and communication between family members, the emphasis has come to be upon group sharing, joining things together, watching things together. Adolescents, when faced with a recrudescence of oedipal feelings, find it difficult to sublimate these via other types of familial intimacy experiences, simply and mainly because they just have not learned how. The adolescent is trapped. He either leaves the home and looks for intimacy outside, or he remains within the home and suffers the threat of massive regression to those types of oral and anal intimacies that he knew earlier in life with his parents. Should he choose to leave the home in an effort to seek love and intimacy, he has had very little experience with intimate communications and winds up, I feel, substituting physical-sexual "intimacies," or the pseudointimacy of the hippie and drug scene, for human closeness.

The paper includes a discussion of the changing *role of womanhood* with subsequent identification by young girls with their mother's more assertive and liberal attitude toward sexuality. This not only includes more responsive, active attitudes toward sex, but the growing acceptance of older women now seeking out younger men for relationships.

The final part of the paper will pay attention to the effects of the war, the threat of the bomb, and other social eruptions as well as potential eruptions, as these affect the adolescent's fear of castration and total annihilation. The adolescent not only can project his own guilts onto an ambivalent society but can also rationalize acting out of conflicts with the reality-tinged justification of "Why not live and 'love' while one still is alive and has a chance to do so?"

SOME IMPLICATIONS OF THE SEXUAL REVOLUTION FOR ADOLESCENT SEXUAL CONFLICT

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Does the sex revolution involve changes only in attitude or are there also changes manifested in behavior? Are these the views and actions of a prophetic minority, the wave of the future, or rather of a fringe group, licentious and rebellious? Is this revolution or evolution? Is it only among the young, or does the older generation also participate? Will it lead to a decline in social morality, or to a greater human happiness? Why is it happening now? What are some of the implications of these changes for adolescent's sexual conflicts?

The paper reviews the changes in attitude toward sex in adult society, using as examples law, medicine, and religion. It then reviews the changes among the young, reporting evidence that the change is more in attitude than in behavior, but also indicating and illustrating with case examples the development of a new sexual morality based on reason rather than myth and superstition.

Some of the causes of this change are then considered, such as the decreasing impact of religion and the increasing impact of science, demands of women for equality, development of penicillin and the pill, etc. The paper then considers the implications of these changes for adolescent sexual conflicts by presenting two kinds of clinical illustrations: those patients whose conflicts are lessened by the change; those whose conflicts are made more intense.

THE SEX REVOLUTION AND THE ADOLESCENT'S SEARCH FOR IDENTITY

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The changes in sexual attitudes and behavior of adolescents is a reflection of the increasing openness and candor about sexuality in contemporary adult society. Sexual freedom is also a reflection of the revolt against totalitarianism and political repression.

In an age of rapid change, great confusion about values, poor communication between parent and child, and the pressures on adolescents to make their own decisions, sexual and others, create much anxiety. The push to develop autonomy and gender identity earlier than in previous generations creates tendencies toward precocious behavior and premature foreclosure of alternatives. Peer-group pressure is a potent factor in this process. For some college youth, drugs become a defense against these pressures, and pseudoautonomy is misidentified as genuine growth and maturity.

The sexual revolution has different effects on affluent and poor, on black and white, on college and noncollege youth, on males and females. These differences affect in different ways the adolescent's attempts to understand his own sexual feelings, to explore the nuances of male-female relations, to develop his gender identity and a genuine capacity for intimacy.

The search for identity in adolescence is difficult under the best of circumstances, for it requires a stable continuing set of values, ideals, and expectations of the self, reinforced by society's responses to one's career aspirations and the developing capacity for appropriate and intimate human, especially male-female, relations. In our contemporary age of ambiguity, the search for identity is made doubly difficult, so that it should not come as a surprise that many of our youth become alienated. Today's young rebels become tomorrow's committed adults, but the apathetic or alienated, finding drugs safer than sex, present a much more important mental health problem than do the sexually free intimacy-seeking young people of today, or even those inhibited self-conscious young people found in every generation who postpone intimacy until young adulthood.

SEX AND THE NORMAL ADOLESCENT

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Within the context of a project on typical or normal adolescents, we studied the manifestations of sexuality throughout the four years of high school. We also

obtained followup data on the sexual feelings and behavior of a large number of this group (>85%) for the first two post high school years.

The overall purpose of the modal adolescent project was to examine the relative influences of internal psychological and external environmental factors on the functioning of typical or normal adolescents over a significant period of time. In order to select as typical a group of teenagers as possible, we administered, in the fall of 1962, our Self-Image Questionnaire to a group of 326 freshmen boys and 30 freshmen girls in two suburban high schools. 103 boys and 10 girls met the statistical criteria for inclusion in the modal sample. Of these 73 boys and 6 girls have remained active in all aspects of the project throughout the high school years.

Each subject was interviewed eight times by the same psychiatrist during the four years of high school. Each subject had a complete battery of psychological testing (Rorschach, TAT, and Wechsler Verbal IQ) administered by a clinical psychologist. During the junior year 98% of the mothers and 72% of the fathers were interviewed. The subjects' school records were available to us.

During the freshman year, 55% of the boys had dated at least once. Among the active daters (15%), kissing and necking were the prominent ways of expressing affection. During the junior year, 30% of the boys who dated actively had engaged in heavy petting. By the senior year, 95% of the boys were dating and girls began to play a more prominent part in the lives of these adolescents. No subject admitted participating in overt homosexual behavior, though two subjects had serious problems with exhibitionism and one with voyeurism. Masturbation was prevalent but not cited as a problem area.

The freshman boy might come to an interview dressed in his football uniform and blushing tell us there was plenty of time in the future for getting involved with girls. By his senior year, the boy who was not dating was upset by his own "shyness" or "fears" which prevented him from asking a girl out. His more social counterpart now wanted to talk about his dates or dating techniques, though rarely about a particular girl or her personality.

By the end of high school, only 10% of our group had had sexual intercourse. The figure had climbed to 30% by the end of the first post high school year. Most of the other subjects dated actively after high school, but without striving for emotional intimacy with the girl.

Our data concerning adolescent girls is obviously less complete. The six girls whom we studied in depth showed more and earlier concern about sexual feelings than the boys. Five of the six girls had dated by the end of the freshman year. They were concerned with "how far should they go?" By the end of the junior year, half of them had experienced sexual intercourse and one had an illegal abortion.

We found that in the group of teenagers we studied there is little evidence to support the presence of a "sexual revolution." In our sample the adolescent moves slowly and gradually in the direction of heterosexuality.

THE DOUBLE STANDARD AND MALE DOMINANCE IN NONMARITAL LIVING ARRANGEMENTS: A PRELIMINARY STATEMENT

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The purpose of this research was to investigate the potential impact on American marriage of a selected sample of college students living together premaritally. The study in some respects parallels the work of John Cuber, who has done research on sex-role creativity within marriage. Cuber suggests that a crack in the monolithic establishment of monogamous marriage is appearing in the upper middle classes; this paper likewise suggests that a new adaptation of college youth might also have some potential effect on the future of monogamous marriage.

Background factors leading to nonmarital living arrangements on campus are discussed, as well as factors relating to the development of a new humanistic ethic among college youth, which include: (1) stress upon higher education, liberal content in this education, and high stress on autonomy and democratic decision making; (2) the greater diffusion of a comparatively new honesty ethic among college youth; (3) the relative failure of the deferred gratification pattern, especially as this relates to premarital sexual involvement. Other factors include an increasing alienation and the failure of youth to become articulated into the conventional institutions of our society. Whatever the reasons, increasing disenchantment with established convention and ordinary institutional imperatives is evident.

A set of rationales is provided as alternative explanations for the apparently growing phenomenon of nonmarital living arrangements on college campuses. These range from the possibility of latent communications from parents which support this style of deviant behavior to the kind of interpretation imposed by Marshall McLuhan. The onset of an immediate gratification pattern, when coupled with the use of the pill, appears to have created an increased potential for those nonmarital living arrangements. The intensification of a humanistic love ethic, coupled with an emphasis on honesty and existentialist involvement in the world, all appear to be related to this relatively new style of behavior pattern.

55 in-depth focused interviews were coded, classified, and used as the basis for the formation of a tentative typology of nonmarital living arrangements: first, the "love child" or relatively promiscuous type of adaptation; second, the "weekender"; third, the "experimental semester" type adaptation; and fourth, the "premarital testing" type of relationship. Mechanical and interpersonal problems are noted as relating to types of living arrangements.

Implications for the future demise of the double standard within marital relationships are discussed. Both short- and long-term consequences for the individual and society are noted, most specifically involving changes in marital expectations of females as they experience relatively greater autonomy and freedom within these premarital living arrangements. A long-term prediction noting the possibility of more rational and satisfying marriage relationship is extrapolated on the basis of the data as a tentative possibility in the future.

RAPE, RESPONSE, AND RESOLUTION: THE USE OF SUPPORTIVE MENTAL HEALTH SERVICES WITH VICTIMS OF SEXUAL ASSAULT

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Many young people today are interested in working and living with poor people. As a result these youth are thrown into unprotected relationships for which they have been ill-prepared by their past experience and which they often misinterpret. Rape of these youthful workers has become a matter of increasing concern.

The writers, working as a crisis intervention team in a community mental health setting, have identified and described three phases in the predictable reaction of young women who have been raped. The study includes 13 women, ranging in age from 18 to 24, all of them white youth who have moved into disadvantaged communities to implement their conviction about "doing something real" in contemporary society.

The writers have defined three phases of reaction extending over a period of weeks or months following an actual or imagined rape. Phase 1, the time immediately following the assault, is characterized by shock, anxiety, disbelief, and dismay. The immediacy of the report, the person notified, and the decision about informing the family raise practical issues that must be considered with the patient and are discussed in the paper. Phase 2, often mistakenly thought to represent a successful resolution of the reaction to the rape, includes denial of the impact of the alleged assault and is characterized by pseudoadjustment and return to usual activity. Phase 3, frequently unrecognized or misdiagnosed, includes depression and the need to talk. Issues which have previously been dealt with superficially in Phase 1 or denied successfully during Phase 2 reappear for more comprehensive review and resolution. Case examples illustrate each phase.

The predictable nature of the three phases of reaction to rape is emphasized. Definition of the nature of the expected responses to the trauma has permitted the authors to develop a successful pattern of short-term supportive mental health services with emphasis on the use of anticipatory guidance and crisis intervention. The paper describes the outcome of the 13 cases studied.

YOUTH AND SEXUALITY: LEADERS PREPARE FOR NEW CHALLENGES

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Requests for leaders increasingly come from youth and parent groups asking sex-oriented questions and searching for understanding during a time of cultural transition in attitudes, behavior, and moral values. This report is based on an NIMH project (1964-69) designed to educate pastoral educators to assume new family life leadership roles with youth and adult groups.

Each NIMH Fellow spent a one-year sabbatical studying counseling and family life education skills. A total of 25 faculty members from Protestant and Catholic seminaries and universities participated. A major focus of the program was to prepare these faculty leaders to understand and meet the teaching challenges deriving from youth's sexual interests, hopefully to reach them before rather than after their premature sex activity.

In studying the "counselor-educator" approach, these pastoral educators needed to assess their own developing sensitivity to the feeling levels of young persons as well as to their educational needs. They needed to learn to anticipate each group's unique personal problems and cultural pressures, to stimulate good dialogue and argument, and to encourage youthful participants to examine their own attitudes in interpersonal relationships. Preparation for leadership roles included studying the leader's personal answers about human sexual behavior that boys and girls would really consider.

A total of 200 meetings and 2,500 contacts with youthful participants took place under the project. Written audience evaluations were collected during and following a series of meetings. Tapes of meetings and other evaluative reports were also studied.

The philosophy and methods underlying leadership roles which might successfully make contact with youth are described through an illustration of one of the pastoral leader's use of the "counselor-educator" approach in his community practicum. He made administrative community planning and evaluative meetings part of a sex education series given teenage girls in the county house of detention (the girls were awaiting adjudication of the juvenile court charges against them). This community experience was part of the project's planned leadership sequence, which also included seminars and scheduled individual supervision. The pastoral leader, with prior experience in university teaching and state mental hospitals, reassessed and correlated his therapeutic and educational goals in this new type of experience. The teenage girls, caught not only in sexual and moral problems but with heightened tensions in their relationships to authority figures as well, did actively begin to participate in a meaningful learning situation. As the leader reached the feeling level of these girls, in sensitive and educational ways, the girls could then begin to enlarge their view of sex acts and could also begin to consider how to sustain a human relationship before and after the bedroom scene.

The NIMH evaluative data from the five-year study does indicate that adolescent youth, whether from blighted or affluent neighborhoods, will respond to an educational agenda emphasizing personal and interpersonal dilemmas. It needs to include each one's central and widened sexual concern: how to find and know love and how to be loved in return. The reports give suggestions for further research and study, and indicate additional limitations and guidelines for consideration.

THE SOUNDS OF THE TUNED-IN GENERATION

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The lyric themes of popular music appealing to adolescence in the late 1960's, in contrast to the idealized romantic themes of the 1940's, reflects a pronounced concern with personal and social values. "Who am I and where am I going?" and "What should I believe in?" predominate as the central questions the tuned-in generation are concerned with. Much of today's popular adolescent-oriented music reflects a sharp contrast to the Tin Pan Alley dominated romantic notions of cokes, dates, and idealized romantic interludes that characterized previous adolescent generations' musical interest. For the first time in the history of commercial music, adolescents are writing, playing, and producing their own "sounds." Thus, their music represents one avenue to understanding their thoughts, feelings, and conflicts.

Between November 1967 and October 1968 an analysis was made of the "big charts" (weekly ratings of the top 30 popular records) of recordings aired to the audience of a teen-oriented radio station in a large industrial New England city. The radio audience was predominantly white (the city's black population is approximately 1%). This particular station's musical selections were in contrast to those of other radio stations playing predominantly soul music (James Brown; Aretha Franklin), acid rock (Big Brother and the Holding Company; Blood, Sweat and Tears), or straight commercial popular music (Barbara Streisand; Tony Bennett).

The style of the music reflected a synthesis of rhythm and blues styles of the 1940's (associated predominantly with the black population), rock 'n roll of the 1950's, gospel, country, and western folk music, soul (combination of blues and gospel), East Indian sounds, and folk rock (rock music combined with folk). A further subclassification of the style was that listed under "sounds," including the California sound (or the acid rock), the English sound (dominated by such groups as the Beatles), and the Detroit sound (dominated by such groups as the Supremes and the Temptations).

This analysis was concerned primarily with the lyrical content of the music. The music expressed audible sounds of a young generation that have so far removed themselves from conventional American life as to create an identifiable "gap." Tragically, most parents of this tuned-in generation neither hear nor feel any desire to listen to what is being expressed (this despite the larger and larger "blasting"

electronic amplifiers the young musicians utilize). The music reflects in part the conflicts all adolescents experience between security and independence. A closer analysis, however, reveals an aggressive challenge to the Establishment's values and the protest voice of the young against adult hypocrisy. In a sense, the tuned-in generation have fostered through their music a curious poetic-sociological musical movement. While they make their criticism through ridiculing the adult values, there is beneath this "put on" a sense of urgency and anxiety about the world that they will be responsible for and the roles that they will perform in that world.

While the central themes may disguise the tuned-in generations' fear of responsibility which awaits them and concern about control of impulses in a society where great conflict and uncertainty about traditional controls exist, there is nevertheless much to be learned from their music about this adolescent generation's view of the world that they live in.

The themes identified include: (1) communication gap, (2) sexual values, (3) hypocrisy, (4) society—its future, (5) interracial romance, (6) one parent family—divorce, (7) loneliness, sadness, loss—lack of understanding, (8) drug use, (9) cheating and deception, (10) peace and war, (11) depersonalization, and (12) freedom. These themes in essence reflect pretty clearly the kinds of things the current adolescent generation feels has forced them to put the gap between the generations. Technological advances in our society and the considerable affluence, particularly associated with the middle class, have been instrumental in allowing the tuned-in generation to express their views in their music.

YOUTH CULTURE IN THE NEW SENSIBILITY

*Edgar A. Levenson, Arthur H. Feiner, Nathan Stockhamer
William Alanson White Institute, New York, New York*

The theme of this meeting reflects its inherent bias as well as its best intentions. Youth is not "in transition" nor is it going anywhere. Youth is, more simply, somewhere else. Parents and psychotherapists alike run the risk of "old fogeyism"; namely, the tendency to see the new as *nothing but* an aberration of their old familiar experience. Youth culture is entirely consistent with other aspects of contemporary society.

Ours is the age of electronics. Accompanying a vast technological revolution, there has been an equally pervasive and parallel change in scientific concepts, the aesthetics of the culture (arts, theatre, literature), sociological trends, and even patterns of social and psychiatric aberrancy. The young adult is the man of his time. Much of the behavior that we find most irritating and incomprehensible is totally consistent with this new world. His language is largely electronic. Terms like "turn on," "tune out," "blow your mind," "freak out" are from the lexicon of the vacuum tube. The young adult's language may seem to be stereotyped, limited, and without much expressive range. It is not, however, if one recognizes that it is not a content-

oriented language as is ours. It is a language which is very highly patterned with a rich nonverbal metacommunicational system. As with computers this kind of communication depends upon the pattern of information not on the content. Much of the new science, general systems analysis for example, is much more readily accessible to the young than to us.

It must also be understood that young adults live in a world dominated by aesthetic considerations. Even their morality is essentially aesthetic: "If it's beautiful do it." Since they are not concerned with problems of right or wrong, duty, responsibility, the Protestant ethic of work, they tend to frighten us. They are, in that prime epithet of old fogeyism, "amoral."

Yet, they are also political activists, and antiwar demonstrators. How is that possible? In a world where information lies in idiosyncratic patterns, there is a great respect for individuality and private solutions: note "doing your own thing." One sees this emerging in traditional sociology and psychiatry, where absolutist distinctions among peoples are disappearing. Criminal, noncriminal, psychotic, nonpsychotic are no longer the clear antitheses they used to be.

The psychotherapist, by virtue of his age and training, is essentially a scientific traditionalist. His paradigms are largely those of the mechanical age. Regardless of his metaphors (Freudian-Sullivanian-Rogerian) he thinks in terms of drives, forces, counterforces. His moral convictions and his social goals for himself and his patients are essentially conservative. His tendency in confronting the young adult is to treat him as an aberrant product of his own society and attempt to reform him. This effort, when successful, is frequently laudable. But with the wary original and creative members of the new sensibility it can be a tragedy. The problem the therapist must face is that of obsolescence and relevancy—his own: obsolescence because he must deal with people who talk a different language and use a different set of concepts; relevancy because the patient does not come for the traditional reasons, does not have traditional symptoms and is not satisfied with traditional solutions.

In the days of the machine society, neurotic systems were essentially malfunctions: the machine clanked, clunked, or broke down. We treated a patient for hysterical disorders, impotence, obsessional unhappiness, etc. In the days of the electronic technology, our patients are essentially asymptomatic. They seem to be suffering from problems of involvement or fidelity, in other words of finding their place in the pattern or in the larger general systems. Eric Erikson called the problem of fidelity the characteristic difficulty of the older adolescent or the younger adult. As therapists we can stay in our safe but anachronistic world. We can sustain our tautologies by treating patients who have anachronistic symptoms. If we go into the brave new world, we must be prepared to have not only our concepts challenged, but our very idea of our own relevancy and purpose as well.

The young adult leads us also to an examination of the phenomenology of choice. We must learn why when two students quit college, one goes into a schizoid deterioration in a communal pad, the other tries that for awhile but goes on to some highly creative activity. We must recognize that psychotherapy is no body of eternal truths, but a changing part of a changing culture. Our patients, their diseases, our

concepts, our functions are all in continuous flux. Without perspective and without an open-endedness in our concepts we are doomed to obsolescence and irrelevancy.

THE WORLD AS AN ELECTRIC CIRCUS: YOUTH AND EXPERIENCE

Rev. Dennis C. Benson

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This paper could be called the "liner" notes for the mixed media presentation to be given as part of the symposium *Clergy Look at Youth*. The author brings together random segments from his experience and training in the world of the electric age. This is not an exercise of psychological experimentation. The locus of his present mindset has been shaped by a cross section of people, young and old. The author's task has been that of an enabler for the young and old to do "their thing" with others. The framework of this experience must be labeled "faith" centered in a "zen-Presbyterian" way. The media and the messages of his life and thought are inseparably mixed. Such a stance has shaped both message and medium. A cadre of teens and adults aided in the preparation of the paper and the multimedia experience to be shared.

THE COOL VOICE IN STUDENT WRITING

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On June 9, 1968 I described in *The New York Times Book Review* what I see as a new type of story appearing in college classrooms: technically competent and exciting but lacking in compassion and often devoid of emotion. They are stories of isolation and almost complete passivity. This paper looks further into the new type of story to point out what literary and social influences may be acting on the students and to ask why they are acting at this particular time.

The nature of the paper is descriptive and subjective and the method is memory. Creative writing classes in the 1940's and 50's, as I recall them—and as I know they were from reading college literary magazines of that era—had stories that followed patterns as rigid in form and subject matter as the fairy tales and classical stories of early childhood. Certain stories appeared, and still do, with durable monotony: stories of the loss of innocence; the death of a parent; the suicide of the narrator; the daydream of romantic conquest by the young girl narrator; the young girl taming or subduing a horse; the fatal accidents which in the last paragraph solve all narrative and emotional problems; the self-pitying stories by white authors on the injustice of being born black.

In the early fifties, working in France on *The Paris Review*, I first became aware of a new type of story. Deriving from Sartre and Kafka and Becket, sometimes these stories were by old and established writers such as Dino Buzzati (story plot given) who had seen their country's heroes defeated, their homelands devastated. More often they were by young writers such as Holland's angry and disillusioned Van Het Reve (plot summary). Almost always they were by men who had reason to doubt the wisdom and integrity of their leaders. The stories, years ahead of black humor, but suggesting it, were cool in the extreme.

These stories today by young Americans are cool. And their authors, too, when questioned, point to the progress of the war and "manipulated" peace in Vietnam, the assassination of Martin Luther King and of Robert Kennedy, the Chicago riots during the Democratic convention, and say either that they feel they have no choice about their destiny or that any choice is meaningless because it will not be heard.

By paradox, the majority of these students are active in social reform programs, antiwar demonstrations, antisegregation organizations, and in campus reform politics. I remember Metellus, the young soldier who defied Julius Caesar by standing between him and the doors to the Roman treasury and to whom Caesar said, "I could kill you," and then added, "And this, young man, is more disagreeable for me to say than to do."

I draw no conclusions. I suggest that it is easier for the students as for Caesar to act against established authority in which they lack faith than it is for them to know or to describe the emotions which have lead them to action. Their most serious attempts to describe who they are and what they are doing seem, therefore, to us who are used to emotions in literature, "cool." I draw no conclusions but often when I am working with these students on their manuscripts I ask myself, and now I ask you, if a loss of respect for those in authority causes a deadening of emotional tone, and creates finally the cool voice?

FROM PANIC TO PANACEA: DYNAMICS AND REFLEX: THE DESIRE FOR EFFECT

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1. Literature of youth considered as common artistic creation. Two impulses involved: the desire for effective communication (achievement of sense of community on nonsocial, vicariously personal, or spiritual level) and the desire for expressionistic release. Strong tendency of impulses to be mutually exclusive. Talent or genius as ability to synthesize these impulses while retaining the tension necessary for attention.

2. Literature of youth considered as a mirror of "the best of times and the worst of times." Simplistic and complex readings. The failure of both writers and critics to credit the process of perception (the triumph of achieved articulation and an

awareness of the impossibility of complete articulation) as being in time and as a primary problem-subject of artistic creation. Special implications for concept of youth-in-revolt; and limitations of that concept.

3. Literature of youth considered as propaganda. Effect versus affect. The delights of panic and the dangers of panacea: the desire for noneffect. The great cop-out from becoming aware of (overwhelmed by) limitations and impermanence of perceptions. Relation to current "nihilistic" proclamations, and these in turn considered as expression of an artistic obsession with the process of perception.

4. Substance and rhetoric. Insistence on "substance"; style as subject. Exclusionary language (manner) as further example of conflicting impulses for effect and assertion, with the latter misperceived as without regard to the former. The achievement and necessary failure of "telling it like it is"; the achievement and necessary failure of hearing it like it is told. Idealism versus the perception of literature not as a critical mirror for external conditions but as expression of psychobiological patterns, and the casting of reason as enemy.

ATTITUDES OF YOUNG MEN AND WOMEN TOWARD AWARENESS OF DEATH

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It has often been argued that American society is characterized by a denial of death as a strategy of dealing with the universal fear of it. The present investigation attempted to determine to what extent young men and women employ this technique in confronting the problems of imminent and distant death and what attitudinal variables differentiate those confronting and those denying the potential existence of death. Parsons' notion that the inevitability of death determines the individual's ability for acceptance was also explored in this investigation.

Previous investigations of attitudes toward death usually relied on projective tests, such as word associations assessing subject's emotional reaction to or fear of the stimulus word "death." Results of these studies provided few actual clues to the *whys* of these fears and attitudes regarding death. The present investigation aimed to elicit the phenomenological reasons underlying an ability to acknowledge death and fears of such awareness.

Subjects were 90 college students (38 men and 52 women) at a major private university. A semistructured questionnaire was administered in groups to elicit attitudes toward death and inquire into subject's views on whether dying individuals should be informed of their impending death. Subjects were also asked whether they viewed information about ultimate length of life as desirable and if so why. Replies to questions were rated along various dimensions including self versus other referent, reasons for desiring or refusing information about death, and future versus present time orientation.

Findings of the study support clinical observations that for many individuals their perception of death when it is at a temporal distance and their perception when it is personally near may be two quite different matters.

Death was accepted as the inevitable end to a full life cycle by our college sample. Both male and female students concurred that the dying person should be informed of his situation especially if he possesses emotional maturity. Knowledge of death was seen as a form of mastery over impending death in both practical and emotional terms. Females tended to give practical, interpersonal, and other-directed reasons for the necessity of information regarding impending death. Males tended to emphasize the emotional and intellectual importance of such knowledge—contrary to the common notion of male-female differences in attitudes.

Responses regarding knowledge of one's lifespan, i.e., of distant or eventual death, followed a pattern quite distinct from that for inevitable impending death. The former prospect elicited both deep-seated fears and highly personalized responses. Even though questions regarding eventual death were asked in the impersonal third person, the majority of the students applied the questions spontaneously to themselves. Most of the students indicated that they did not want to know at what point in the future their life would end. Major factors underlying an unwillingness to face one's lifespan were fears that such knowledge would change the natural course of life and lead to a death orientation and pessimism both for the individual and for society. Women often voiced fears that knowledge of the future will prove traumatic or emotionally damaging to the individual. For men, however, a major concern was that such knowledge would seriously limit their strivings. Subjects showing future time orientation manifested less fear of death than present-oriented subjects.

Results of this investigation underscore the importance of emotional as well as intellectual determinants of attitudes toward awareness of death. These attitudes differ greatly depending on the imminence of death. Findings also point to the nonhomogenous qualities of fear of death, and indicate the importance of the individual's cultural and developmental context in shaping these attitudes.

RESTIVE YOUTH—HERE AND ABROAD

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The purposes of this paper are to investigate the historical antecedents of present day restive youth, to analyze the psychological and sociological conditions usually accompanying restiveness, and to investigate the similarities and differences of concerns of youth here and abroad.

Material regarding the present situation was obtained by reading current reports and talking with young people from diverse backgrounds, both in the United States and abroad. Interviewing was not based on questionnaires, but consisted mainly of

letting young people talk freely. The historical background was furnished through direct experience and interviews with participants of past youth movements.

Some very basic common denominators of the worldwide protest movement were evident: the anger against the overwhelming power of established institutions and the wish to change this balance of power; the desire to put the principles of human dignity for all and equal justice and opportunity into practice. Beyond these basic concerns, the nature and sometimes goals of the youth rebellion throughout the world have been shaped by the differing social and educational traditions with which they are contending and by the degree of affluence each area enjoys. In the U.S., most striking was the diversity among the restive youth, from those who reject the system itself to those who differ with decisions made by the existing system. The same diversity applies to student revolts around the world, even though there is a great deal of contamination.

The major variable in the success of student movements is the pattern of alliances with other forces in society. It also appears that the so-called generation gap is more imagined than real. Often, both adults and young people share the same social concerns. The difference comes in implementation because of the impatience of youth with anything less than perfection.

IMPACT OF STUDENT ACTIVISM ON THE AMERICAN UNIVERSITY

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The impact of student activism on selected major American universities during the past five years is explored, noting some of the philosophical, psychological, and political differences of activists.

In reviewing the literature, current reaction from outside the university is illustrated. The reaction is mostly negative and tends to play up spectacular events and extreme or violent aspects of activism without adequate demonstrations of causes or beneficial results.

The personal motives of selected student activists are contrasted to value systems demonstrated by university administrations and faculties.

Activism ranging from the Free Speech Movement in Berkeley in 1964 to the Cleaver affair there in 1968 is described. The faculty supported the Free Speech Movement until it realized that the underlying student protest was meant for the faculty and its growing lack of interest in students. Thereafter, it supported the administration. However, the faculty moved ahead at that time to offer new types of courses. One result was a course offered in the fall of 1968 in which both the subject of study and the lecturer was Eldridge Cleaver. The governor of California persuaded the university board of regents to rescind credit for this course and to censure the faculty for allowing it. A student sit-in resulted in a number of arrests and suspensions.

Also described are the Negro militancy at Northwestern University and a study at the University of Michigan.

Psychosocial parameters include positive and negative results, lessening of *in loco parentis* practices, observations on authoritarianism, and increased student participation in decision-making with resulting increased allowance for maturation.

The upsurge of encounter groups on the campus is viewed as an expression of a need for meaningful emotional outlets. Whether changes brought on by student activism will be lasting or transitory depends on the validity of the demands, the continuation of the protest, and the ability of university administrations and faculties to respond to realistic student needs.

A comparison is made between student criticism of the university and psychiatric interpretation. Student criticism is along the lines of wild analysis and may result in a kind of institutional decompensation rather than in progressive change for the better. But if it turns out that the universities have been successful in producing a faculty which can respond to human needs as well as it has to the needs of an industrial society which wants competency, then a rapprochement between faculty and students will make universities viable for tomorrow. Otherwise, universities may simply deteriorate into vocational training schools.

COLLEGE REBELS: TOTEM AND TABOO REVISITED

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The history of the activist movement and the issues and the roles of the participants are reviewed. Psychological aspects of the identity struggle and conflict about disengagement are described. Material drawn from sociological and clinical studies will be offered to demonstrate that this portion of the youth culture is expressing a specific reaction to the cultural crisis of our time.

There is ample evidence of revolutionary changes in attitudes toward sexual freedom, rejection of authority, and use of forbidden words in the behavior of campus activists. This trend has been accompanied by similar trends in our society in recent years. Sociological studies demonstrate that activists tend to come from liberal, well-to-do homes that are atheistic, permissive, and do not emphasize moralism and self-control. Other studies suggest that homes of activists, as opposed to those of nonactivists, did not suppress conflicts but tended to negotiate them.

The authors investigate the relationship between an apparent prolongation of adolescence due, in part, to difficulties in achieving definition and identity and a possible extension of the struggle for disengagement onto the campus. Our material suggests that this portion of youth are deeply involved in new ways with a resolution of intense superego guilt. Some observers contend that the classic superego is disappearing. The authors conclude, however, that from a psychological viewpoint

(not a substantive viewpoint) the activist is struggling to manage unconscious guilt through the symbolic process of destroying all authority totems.

FROM CONFRONTATION TO COLLABORATION: EXPERIENCES AND PROBLEMS

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Confrontation of authority, especially in the school setting, both by minority youngsters and by college students is increasingly frequent. When not understood and badly handled, it leads to counterconfrontation, riots, chaos, disorganization, and revengeful calls from the community for law and order. This paper analyzes some of our experiences in the schools in attempting to utilize mental health personnel to help teachers and administrators with problems around confrontation. Some of the problems that we encountered and some of the lessons learned from our failures are also indicated.

Basically our method was to use a demonstration-consultation combination in which demonstrations of individual confrontation and their handling by other individuals were first presented to small groups of teachers and later to administrators. The staff members who were the confrontees were able to do an extraordinarily realistic job. Those who were confronted tried to indicate the alternative methods of handling confrontation. Some of the issues which seemed to be related to the reasons for confrontation also began to come clear in the course of our work. In some instances the use of individual consultation with teachers and administrators following the demonstrations made it possible to help them with underlying problems about authority, lack of relevance of the curriculum, ineptness of some individuals in their ability to teach youngsters or subject matter effectively, and the need for change in methodology and adaptation of new methods to new problems.

From our several failures we were able also to understand some of the inherent problems in confrontation and to recognize where we were likely not to be successful. A few principles underlying difficulties in handling confrontation seemed to evolve and these are briefly described.

It is our hope that this paper will stimulate others to look at the problems of confrontation, especially in schools, and the potential roles of mental health professionals and educators in helping resolve some of the problems and finding new roles for themselves.

THE SILENT VIGIL—A STUDENT NONVIOLENT DEMONSTRATION

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This paper, together with tape vignettes and slides, documents and analyzes the response to the assassination of Martin Luther King, Jr. of students in a small, predominantly white middle-class southern university. Spontaneous student discussions resulted in a petition presented to the university administration deploring existing discriminatory practices and requesting steps to increase the minimum-wage level of all nonacademic employees to the Federal minimum and to create a student-faculty-employee committee to mediate worker's grievances. While awaiting a response to these requests, the group organized itself into a "Silent Vigil." 1,500 students, some faculty and employees gathered on the main quadrangle and for five days sat, studied, ate, and slept in dignified silence to dramatize their concerns for social and racial justice. The students directed and monitored the Vigil with remarkable organization and self-discipline. Their demonstration was, to the authors' knowledge, unique for its nonviolent nature and effectiveness.

Data include: observations of the authors; all publications released by the Vigil committee; coverage in student, local, and national news media; interviews with student leaders, participants, nonparticipants; questionnaires on motivations for participation; private letters; papers written for courses; pictures; tapes covering a chronological account of discussions and speeches.

Analysis of these data indicates a cluster of interactive factors rather than a single event or ideology which influenced the course and outcome of this demonstration. These factors included: (1) characteristics of the student body, faculty, university administration, and the nature of the relationship between these; (2) the immediate precipitating event—the assassination of Dr. King—and the students' respect for his philosophy and work; (3) the choice of action aimed at an already defined and accessible university problem which seemed amenable to immediate intervention; (4) initiation and direction of action by leaders experienced in democratic group processes in campus organizations; (5) group process which encouraged discussion of policy and action decisions, organization and self-discipline, and ability to accept reasonable, time-limited progress in achieving objectives; (6) the response of the faculty, individually, by departments, and through the Academic Council, who gave tactical counsel as well as support; (7) the absence of restrictive and punitive action by the administration and its willingness to engage in study and mediation; (8) the dynamics of late adolescence, particularly the need to establish as an individual identity which incorporates behavior consonant with personal and social values and norms, and to consolidate peer-group identification.

A college demonstration is a crisis which may provide an appropriate, significant developmental experience for adolescents in the struggle for independence and resolution of their need to rebel against, while also adjusting to, authority figures and institutional policies; their need for an ideal figure and a noble cause to express

youthful idealism; and their need to participate in meaningful, self-directed activity. While each college demonstration must be studied in terms of its own circumstances, understanding these factors of local situation, problem focus, leadership, group process, administrative reaction, and psychosocial dynamics of participants is basic in establishing guidelines. The importance of developing such understanding and methods increases with the emergence of student demonstrations as a recognized political and social force in America.

STUDENT CONFLICT—ACTIVITY, AUTONOMY, AND ATONEMENT

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This paper traces the development of an open "sensitivity" group of self-selected freshmen medical students over a one-year period. The attitudes of group members toward the school, "the establishment," social action, and patient care are compared and contrasted with those of senior students rotating through a division of child psychiatry.

The freshman group were optimistic about their ability to modify the school curriculum and faculty attitude, if not in their own time at least for succeeding years. They expressed concern about upper classmen whom they perceived as having "sold out" to the system in order to get through medical school in the least stressful, most socially acceptable way. They were concerned that they, too, would be changed by the system, becoming more arrogant and losing their humanity so that they would ultimately, like many of the seniors, see patients as things rather than as people. In fact, their fears of change in attitude appeared well-founded when the senior classmen were canvassed for their opinions. The increase in cynicism and decrease in humanitarianism described by Eron were very apparent in the seniors' attitudes toward patients.

In the freshman group, feelings of isolation and fear of alienating others, either by criticism of others' behavior or conversely by expressing any positive feelings, were expressed. Conformity and passivity were viewed ambivalently as safe and yet at the same time pathetically inadequate. The desire to take individual and group responsibility for student action gradually prevailed over the fears of ridicule and faculty reaction. Anger at the "over 30's" and a guilty reaction to what the students viewed as their parents' materialism lead to dramatic action outside the group. During the year one member started a student-faculty social hour, one started a local chapter of a student activist organization, and a third began a series of discussions for the whole class on medical ethics. Later in the year the group members began to see their discussion of such activities during group sessions as a defense against examination of their own motivations. The cry became, "Are We Really as Liberal as We Think We Are?" They expressed awareness of the comfort in the vociferous and large minority group to which they belonged in their class, but at

the same time they began to be concerned about more "conservative" students with whom they no longer communicated and they expressed the need to maintain a dialogue with these more conservative elements.

CONFLICT AND COMMITMENT IN A CATHOLIC NOVITIATE

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In the summer of 1967, the director of a novitiate for training Catholic brothers requested consultation regarding adjustment of the brothers to community life, to the training program, and to living conditions within the religious atmosphere. The goal, within the atmosphere created by Vatican Council II, was to make the novitiate program more meaningful and relevant to those who elected to join it. The authors' professional involvement allowed intensive observation of the formation and conflict of a religious commitment vis-a-vis the psychological demands of a religious order and the individual development of a spiritual way of life.

The population involved in this clinical examination included young novices, avowed brothers, and boys in the high school juniorate which serves, in part, as a feeder for candidates to the novitiate. The consulting program, offering two psychologists and a psychodramatist, involved the entire novice population—20; the entire brother population associated with the novitiate and high school—8; and those high school students referred by staff because of identified problems which needed psychological help. Each group participated in 10 months of psychodrama. Those who desired could refer themselves for supplementary counseling on an individual basis. Pertinent information about individual commitment was also gathered by questionnaire.

Surprisingly, analysis showed that initial election of religious life was infrequently related to religious dedication per se. Reasons for joining the order were vaguely defined but appeared related to the age of election. Those who began commitment prior to age 17 were heavily influenced by an adult brother who served as an ego-ideal. Election at a later age involved varied motives—pleasing family, peer pressure, exposure to a potentially enjoyable life, searching for certainty and authority, escape from an assumed superfluous lay life, etc.

Because religious life often differed from the novices' expectations and imposed real demands on life style, conflicts were inescapable. The loss of certainty in a changing church, inability to test capacity for heterosexual adjustment, difficulties with religious aspects of the life, all created potential difficulties for the novice, in

addition to the usual adolescent problems with authority. Case material illustrating these difficulties and steps in their resolution will be presented.

While young novices exhibit considerable anxiety or rigidity about commitment, the professed brothers, from 10 to 30 years older than the novices, had a different type of concern. Because a number of professed brothers had recently given up their vows and left the Order, the question of retaining commitment had become pertinent. As one would expect, with their increased maturity, the depth in which older brothers considered this question was greater. They found the Brotherhood a meaningful and useful style of life, but a number of them seriously wondered what they were missing by not having a mature heterosexual experience, sharing completely with one other human being. Psychodrama brought to life many old and varied self-doubts, particularly around the sexual area. The brothers were aware of lay and professional peoples' critical attitudes toward them with respect to sexual identification. Perhaps because of this, the question of their own sexual adequacy, which had no opportunity to be realistically validated, remained a concern for many.

The group process in the novice program was carefully monitored by repeated sociometric processes. Of note was the general tendency for individuals to drop greatly in sociometric status prior to electing to leave the Order. It was not necessarily the case that the most isolated in the group chose to drop out. There appeared to be no place within the group structure which guaranteed commitment. Drop in sociometric status was evident for some who were stars as well as for some loosely attached to the main body of the group. In some cases, loss of popularity caused increasing dissatisfaction resulting in exit, while in other cases a fall in status seemed to result from the member's verbal rejection of the Brotherhood as a way of life. At times, the novices who chose to remain would not tolerate criticism of the life style they had chosen, and they retaliated by rejection.

THE ECONOMIC CONTEXT OF THE STUDENT ROLE

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The purpose of this paper is to scrutinize the assumptions underlying the peculiar economic position of secondary school and college students in the United States, and the social practices these assumptions legitimate. The ways in which these practices then affect the definition of the student role in society, and benefit or penalize individuals in other roles, are then considered. The possible effect of alternative social arrangements on youth and on related social institutions and the consequent expectation of resistance or support for such alterations is discussed.

Education in our society is assumed to be a form of "investment in one's future." Since, in our culture, economic interests and motivations are held to be morally as well as practically fundamental—property rights, for example, are more easily defended in our courts than personal rights—much of the moral hegemony of the

school and the legitimacy of its demands is derived from this assumption. Without it, compulsory school attendance would be regarded as involuntary servitude—possibly justifiable socially in the same terms as military conscription but not as a form of service to the student. Secondary school students are paid nothing; stipends for university students are considered adequate if they permit the student to maintain a minimal standard of living and are selectively awarded according to need; young wives are expected to support their student-husbands.

Yet, compulsory school attendance and the maintenance of college enrollment as the only viable course for young middle-class males have consequences clearly more beneficial to other social groups than to youth itself. Unemployment rates run about three times higher among persons below 25 in the labor force than among their elders; if young men were free to compete for any job they were competent to fill, the labor market would be flooded. Schooling and military service, costly as they are, cost far less than payment at prevailing rates for time spent in school, college, or the armed services if these were regarded as inservice training for social participation rather than as an "investment in one's future" or some tax obligation peculiar to youth and payable only in kind.

The schools, moreover, are an enormous vested interest. The present annual U.S. budget for education, about 30 billion dollars, is twice what Hubert Humphrey estimated a volunteer army to replace the Selective Service System would cost. He concluded we couldn't afford it.

To substantiate the claim that schooling is an "investment in one's future," data are invariably cited to show that both individual earnings and economic productivity rise in proportion to the level of schooling completed. But so long as schooling—rather than demonstrated competence—is the sole avenue to the credentials required for job opportunities, and so long as legal sanctions are imposed on any youth who seeks to qualify himself outside school while society suppresses as unlawful and delinquent any arrangements he may make to do so, this argument cannot be evaluated. All that is certain is that the school is the major instrumentality by which the status of "youth" is institutionalized in society; and that the roles assigned persons who hold this status are economically the most meager and subordinate that the society affords.

WORKING CLASS YOUTH: ALIENATION WITHOUT IMAGE

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To a degree possibly never experienced before, ours is a society whose prevailing image of its youth is one of discontent and alienation. This appears true of both the professional literature and the mass media. The accuracy of the image, particularly the degree to which it describes most young people, is open to question, but that is not the intent of the present paper. However limited or inaccurate this image of

alienation may be, it is marked by a crucial short-coming: our current image of American youth appears to be drawn exclusively from the upper and lower reaches of the society. Between the largely upper-middle class and middle-middle class youth who are expected to go on to college and the economically deprived living in "cultures of poverty," there is a void. Possibly it is only those who are sufficiently articulate to voice their discontent or those whose behavior is dramatic enough that compel us to believe that they are really alienated. Or possibly there really is an absence of alienative strains in that large group of young people who are lower-middle class or are children of the working class. The author feels that neither is accurate and that we have not observed the quality of discontent within these latter groups because we—society as a whole as well—have just not bothered to look. (Perhaps one positive outcome of the surprising strength shown by the Wallace third party candidacy will be a willingness to focus both attention and social programming upon this segment of the population.)

One way in which the society, intentionally or unintentionally, acts to constrain the alienative tendencies it sees is to respond to these assumed tendencies by offering public images of that attitude (which, if nothing else, lessens the alienation to some degree by saying: we know that you are there and that you are unhappy) and to some degree by offering programmatic alternatives. However inadequate the images or alternatives may be, they at least make some part of the behavior of the young referential to the society. (An interesting question, though one also outside of the scope of the present paper, is the degree to which this societal response creates the specific forms of alienative response by providing a role description, a sense of costume, and a suitable rhetoric for an alienative posture either poor and black, college, or hippy style). One aspect of or potential for alienation—one that in the recent past was frequently used to illustrate the alienative relation of the Negro to American society—is the failure of the society to offer a recognizing or confirming image of a particular group within the society. That essentially is the situation of most working class youth today.

In some sense the working class has never been substantially represented in the cultural iconography of the society, yet there used to be enough near-heroes and the image of the society itself was sufficiently reinforcing of working class self-concepts and values to be supportive or reinforcing. Now, as the society itself changes and the range of societal self-images has shifted rapidly, the possibilities of self-recognition for working class youth may have significantly lessened. They may well be looking toward the society for some sense of validity of who they are or who they would like to be and they may be looking increasingly in vain.

Unlike the familiar forms of alienation which characteristically involved either a detachment from or the inaccessibility of the traditional values of a society, the young in the working class (like many of their elders) may be experiencing growing feelings of alienation as they cling to traditional values in a society that has become less traditional or, at least, less willing to glamorize traditional values. And though the route to alienation for these youths may in this sense differ, it does not follow that the consequences for them need be any less disordering, pathogenic, or painful.

In this context we will look at some of the conflicts and ambivalences that characterize the attitudes and expectations of working class youth with regards to their sense of the larger society and their role in it, towards the world of work, of family life, and—most important—towards themselves.

CLASSROOM DISCUSSION OF RACIAL IDENTITY; OR, HOW CAN WE MAKE IT WITHOUT "ACTING WHITE"?

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Emancipation from parents, freedom for sexual exploration, and developing an identity of one's own are areas with which all youth struggle. The youth of the 1960's are forced to deal specifically with an additional problem of racial identity in a transitional society. Unlike other adolescent struggles, there is no model of adult behavior to assist in solving this particular problem. Most of us as adults are currently dealing with our own feelings and fears, and we too are in transition. This paper deals with the processes of one mixed racial group numbering to 10 and two white group leaders as they focused on their responsibility to examine, discuss, and understand their attitudes toward the problem of civil rights and racial equality.

Peck, Roman, Kaplan, and Bauman developed a small group observation form which appeared in the *International Journal of Group Psychotherapy*. We used this form for the 17 group sessions, and the co-leaders recorded on it their observations of the degree of involvement and sensitivities of the group members, as well as patterns of the group and resolutions of issues. The group met for one hour each week; the co-leaders spent the following hour evaluating the session. It was necessary to spend this amount of time because the observation form questions elicited divergent views which were important for the co-leaders to resolve and understand. When writing this paper, the observation form was invaluable in checking hypothesis and speculations made by the co-leaders as the group was progressing. Although we did not specifically measure attitudinal change, the students could state a definite gain in formation of their opinions regarding our problems and tasks in race relations in America.

The group quickly found themselves segregated in their thinking, which came as a surprise to the white students especially. In their zeal to advocate equal rights and total integration, the white youth had not concerned themselves with what this would do to the Negro race. This was a concern to the Negro students. They value the preservation of their race and do not favor assimilation by Caucasians, in the name of integration. Their goal, to have equal rights and opportunities without "acting white," strengthened their sense of being "black and beautiful." The black students

were proud to point out their differences. To become more inhibited, more formal, or to lack "soul" was to lose a very important and natural part of their behavior. Alienation from their black peers was the result of "acting white." The whites felt unwanted and rejected. For the first time they realized that what they had to offer was not totally accepted and sought by the black students.

The adult leaders—a psychologist and a social worker in the pupil services department—volunteered to take part in this project urged by the Equal Opportunities Commission and accepted by the principal of a central city high school. Our traditional role has been to work with youngsters identified by the school as having educational and/or behavioral adjustment problems. The willingness of the school to consider a broader role for its "mental health specialists" provided an opportunity to prove our value to the "goods" as well as the "hoods" of the school. We hoped to enable this group to handle feelings about racial conflict; and to learn through emotional involvement, as well as intellectual exposure.

We had some difficulty in clarifying our perceptions regarding behavior of the white youth. It was difficult to determine whether they acted out of a feeling of fear, superiority, or a little of both. While the social worker became involved in helping the students relate to the broader social problems they face in the school and in the community, the psychologist preferred to focus more on the intergroup process. A problem which we never satisfactorily resolved was how much our own personal opinions and beliefs should be shared with the group. This was especially difficult as the whites were hoping for models and the blacks were pressing for evidence of prejudice on our part.

We accepted the school's proposal that these groups meet during lunch hour and attendance would be voluntary. Both of these procedural guidelines served to defeat some aspects of group cohesion and group process. In the near future we hope to see teachers and pupil service personnel more closely allied in the educational and mental health problems which beset all youngsters regardless of race or social and economic status. Future discussion groups, to be taken by the students for credit, might include such topics as drug and alcohol usage, sexual behavior, cliques, and problems of the generation gap.

CHARACTERISTICS OF JOBS HELD BY ECONOMICALLY DISADVANTAGED YOUTH

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A major obstacle in the development of adequate theories or programs concerned with the vocational adaptation of economically disadvantaged youth has been the absence of adequate information on the occupational experiences of this group.

Detailed information on the job experiences of a group of 18-20-year-old youth was obtained when applicants to four work training programs for "unemployable"

youth were interviewed about two years after program application. Programs were located in low-income neighborhoods of New York City and were limited to school "dropouts." Applicants ($N=112$) were mostly Negro and Puerto Rican. The interviews were given during the period of September 1965 to May 1966.

Job histories were investigated with a focus on these aspects: number and duration of jobs, level and field, source of job, pay, and satisfaction. Characteristics of subjects' first jobs were separately studied, and the relation of ethnicity to job histories was explored.

Among the descriptive findings were the following: Median number of full-time jobs held (to time of interview) was four and median duration was 5-8 weeks. Over one-quarter (28%) had held six or more full-time jobs. Almost all jobs (93%) fell into the three lowest levels of a modified version of the Hamburger Occupational Scale. These levels are roughly comparable to semiskilled level and below. Occupational fields were diverse, but at the relatively higher levels jobs tended to be more concentrated in the production field (i.e., factory jobs). Median pay of 35-45 hour per week jobs was \$53 and median income for the year just prior to the start of followup interviewing was \$29 per week. According to the respondents, most jobs (66%) possessed at least one likeable feature but nothing was liked in the case of about one-third of the jobs (32%). Source of jobs varied, with half (50%) of jobs referred by agencies (excluding school agencies) and about one-third (32%) referred by friends and relatives. One common source (22% of all jobs) was a friend or relative working at the place where the job was available. With regard to first jobs, somewhat under half (44%) began working while still in school and about one-fifth (21%) had first jobs at ages 10-14. Subsequent full-time jobs tended to be of higher level than first full-time jobs but did not tend to be of longer duration.

The descriptive findings support the theoretical hypothesis (set forth by Donald Super and others) of a "trial" or "floundering" phase occurring in subjects' first years of work. The job histories appear to reflect a succession of short-lived jobs. Differentiation existed within the levels characterizing jobs, allowing some room for upward mobility. Income seems to have been exceedingly low, especially since a significant proportion of subjects (24%) were married and/or fathers at time of interview. Judging by number of jobs held and age at which subjects obtained their first jobs, subjects could not be considered unmotivated to obtain jobs. However, the findings concerning duration of jobs suggest that after a job was obtained, its maintenance was difficult.

Among the analytical findings were the following: Pay, duration, and liking for a job were positively interrelated. Source of job was predictive of pay, duration, and, less strongly, liking—with jobs referred through personal sources (friends and relatives, who usually had jobs at the place of the referred job) of longer duration, higher pay, and greater liking. Jobs of Negroes and Puerto Ricans differed with respect to source, pay, duration, and hours.

This analysis was meant to contribute to an empirical mapping out of the problem area with which many programs are concerned. It was undertaken in the belief

that description and analysis of occupational experiences of disadvantaged youth is a logical first step toward the creation of effective programs and the development of applicable theory.

PHASE SPECIFIC INTERVENTION FOR DISADVANTAGED YOUTH: UPDATED CONCEPTS FROM THE JOB CORPS

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The adolescent poor number some 3,000,000 persons, many of whom have "dropped out," "turned off," and "tuned out." These youth generally present marked discontinuities of psychological and social development. They are sophisticated and mature in some areas of functioning, but immature and poorly developed in others. Specifically, while equipped for "life on the streets" or in the "hollows," they are ill-prepared, emotionally and socially, for work or family responsibilities. More than purely educational deficit, this is a matter of psychological and social deficits which are detailed in this paper. These deficits augment the personal barrier implicit in the cycle of failure, low self-esteem, and hopelessness which many of these youngsters experience.

These youngsters do not however define their difficulties in terms of mental health or illness, but instead in terms of social barriers, inequality, and the need for job or vocational training and education. Programs of intervention must therefore focus on issues of work, training, and identity.

This paper describes the psychological and social profile of youngsters who enter the Job Corps and presents actual case illustrations. It then focuses on those aspects of the Job Corps program which promote psychological and social growth along the dimensions specific to the developmental phase through which the Corpsmembers are passing. In the Job Corps setting, the focus on work (but including counseling and group living) is utilized to promote growth, relevant to the issues of identity, autonomy, problem-solving ego functions, ego-ideal formation, and relinquishment of the pleasure principle. This focus provides a basis of relevance, as the youngster sees it, which permits a fostering of productive relationships with peers and adults. These relationships, in turn, permit the design of experiences incorporating the previously absent warmth, success, and "pay-off."

Clearly, the changes which youngsters undergo during their time in the Job Corps require intrapsychic work. Much of this work is performed during critical transition points which all youngsters undergo during their careers in the Corps. It has become clear that the adjustment to a new milieu, to a new way of doing things, represents a series of crisis or transition points each of which must be surmounted. The initial

transition phase, labeled "culture shock" in some settings, is followed by other adjustment phases.

In this paper we describe the expectable life adjustment crises which we have discovered in the Job Corps setting. Based on the results of a statistical analysis of the dropout pattern of Job Corps youngsters together with data derived from interviews which were conducted for clinical and/or research purposes, we recognize certain transition points. These critical transition points during the careers of all Corpsmembers include: (1) The "crisis of arrival," (2) The "crisis of engagement," and (3) The "crisis of graduation." Each of these transition points in the careers of all youngsters at Job Corps centers are experienced internally as periods of crisis by the youngsters. They have the potential of resolution in the direction of growth or of regression.

The work presented in this paper demonstrates that programs designed to intervene in the problems of adolescent poverty cannot be conceived simply as education or job skill training programs. Fostering work adjustment in this group of youngsters requires additional psychological and social development. In order to be effective, programs must be conceived as phase-specific interventions relevant to the needs of the youngsters as they themselves define those needs. Concepts underlying such programs are updated in this paper, based on the Job Corps' experience. The implications of this work for the mental health field and for other less intensive programmatic interventions for disadvantaged youth are discussed.

SOME PROGRAM IMPLICATIONS OF RECENT STUDIES OF NEGRO AND PUERTO RICAN YOUTH IN YOUTH-WORK PROGRAMS

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This paper sets out some of the implications for youth-work programs suggested by the results of two recently completed studies of Negro and Puerto Rican youths in New York City: "A Study of the Meaning, Experience and Effects of the Neighborhood Youth Corps on Negro Youth Seeking Work" conducted by Melvin Herman and Stanley Sadofsky of New York University; and the "Preliminary Research Findings" of the Mobilization for Youth study conducted by Richard A. Cloward of Columbia University. Each study generally confirms the findings of the other.

The results of these studies indicate a basically positive work orientation on the part of disadvantaged youth in New York City. Most of the youth have worked, albeit in low-paying and menial jobs, but enough to indicate a desire and ability to work. The vocational aspirations of the youth in these work programs are generally realistic. While there are discernible differences between different groups, with significantly greater needs for help on the part of some, the work experience after training and placement is generally positive.

Most youths are motivated towards meaningful training, especially specific skill

training, and towards job placement. The high proportion of dropouts is based on perceived shortcomings of the school system rather than on individual failures. There is seriously low self-esteem and a high degree of vocational pessimism which affects vocational functioning. The impact of impaired family structure is significant, although not uniform.

The limitations of the employment programs derived primarily from dissatisfaction with existing job opportunities: low pay and the menial nature of the work available with no apparent realistic opportunities for advancement. The dissatisfactions with the agency work preparation and training programs resulted primarily from inadequate training in specific skills.

These studies suggest that top priority must be given to job creation and job development as a necessary precondition for effective youth-work programing. Until such a genuine and general work opportunity situation has been created, it is difficult and perhaps misleading to attempt to evaluate individual deficiencies related to work and difficult to devise a satisfactory system of vocational habilitation.

Such a "full employment" opportunity structure has not been created for disadvantaged youth in the ghettos, so it is not possible to distinguish effectively that section of the young labor force which is so profoundly alienated and wounded by socioeconomic handicaps as to require intensive vocational rehabilitative care.

INDIVIDUAL THERAPY VS. MASS INFLUENCE IN THE GHETTO

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This paper shares some thoughts growing out of the experiences of a psychologist working with underprivileged youth in their struggle to secure a college education. Clinical psychologists involved in the war on poverty are finding the medical model and their training in hospitals inappropriate in this new area of involvement. The educational model, striving to prepare people for adjusted lives—as opposed to repairing lives—seems more productive. The need to change techniques developed for the treatment of illness to suit the needs of underprivileged youth will be discussed in the paper.

Psychotherapy has failed to effect changes on ghetto youth for many reasons. Prominent among those discussed in the literature is the middle-class therapist's lack of understanding of his patient. Another aspect is described as the inability of lower-class individuals to introspect. This author is of the opinion that these *are* formidable obstacles in effecting change on ghetto youth, but that greater difficulty arises from another fact. For many psychotherapists the basic assumption of psychotherapy is that the individual's responsibility is to learn as best he can to cope with society as it is. This is the assumption that is most antithetical to the current outlook in the ghetto.

Another basic assumption of psychotherapy is that cure comes from the exam-

ination of historical factors within the individual's own life span, that when an individual comes to terms with the effect of his parents on his own life, he learns to deal with the environment more effectively. Again this thinking runs counter to the basic outlook of ghetto youth who are convinced that their problems come from the crippling aspects of society. They do not see the relevance of child-rearing practices to their present circumstances.

As psychologists, we are committed to studying problems and by virtue of our study to develop solutions. In working with blacks we have often failed to study and have rushed in with solutions developed out of our previous experience. Blacks consider us "outsiders." We have considered ourselves "experts." And that is why we have made little headway. In working with black high-risk college students I consider myself a stranger in a foreign land. I come with the desire to learn about my new surroundings. I must leave behind me my sense of security, that I know the way things are. Completely inappropriate is the attitude of "let me show you how to do it" or "do it this way because this is the way I did it." Psychologists must develop the attitude of "we want to understand you and we hope you will understand us." If we forget about "healing" or "treating" and think about "learning," we may have a significant and mutually enhancing relationship.

WHITE COAT VS. CAP AND GOWN

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In response to the anticipated professional manpower shortage in V.A. psychiatric hospitals in the early 1940's, the Veterans Administration, in conjunction with the universities, developed clinical psychology as we know it today. Because of the nature of its birth, clinical psychology followed the medical model. In the early years, until the late 1950's, most clinical psychology graduate students went through the V.A. internship program and many of them, upon receiving their Ph.D.'s, continued to work in psychiatric hospitals.

The urban crisis of today presents a new challenge to psychology as a profession. One of these challenges, in the educational world, is to translate into reality the ideal of equal educational opportunity for all. This writer participated in the development of and currently directs the SEEK Program of the City University of New York. In the presentation he will describe the role psychologists play in assisting black and Puerto Rican students adapt to the college environment.

EXPANDED VOCATIONAL OPPORTUNITIES FOR HANDICAPPED YOUTH THROUGH COOPERATIVE EDUCATIONAL PROGRAMING

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This presentation by representatives of the Bureau of Education for the Handicapped, the Division of Vocational and Technical Education, and the Rehabilitation Services Administration is to stimulate active response by professionals of the American Orthopsychiatric Association and others engaged in human service fields to the mandate posed by Congress in the passage of the Vocational Education Amendments of 1968.

Vocational rehabilitation, traditionally available to the handicapped only upon conclusion of formal education, cannot reach all handicapped youth, nor will all potential clients bring to rehabilitation requisite basic skills and attitudes. Personal characteristics enabling the individual to adapt to the world of work are optimally developed as part of the individual's early years of education. For the handicapped, this means that there must be a close relationship between special education and vocational education and guidance. Occupational attitudes and skills developed early can obviate frustration and disappointment of a handicapped person as an adult.

In recognition that both style and content of vocational education have changed significantly in recent years and that there is an ever increasing gap between the vocational needs of handicapped youth and the habilitative or rehabilitative services provided to them, the Department of Health, Education and Welfare has taken the initiative in stimulating coordinated efforts for planning and development of effective vocational education programs for the handicapped at Federal, state, and local levels. Since the early 1960's, cooperative agreements in the various states between agencies concerned with vocational rehabilitation, vocational education, and special education for the handicapped have brought about the cooperation of these three areas of financial resources and the professionals and paraprofessionals of all disciplines who can coordinate their efforts to prepare the handicapped for realization of greater vocational potential.

THE DRAFT REFUSER AND THE ROTC CADET: A STUDY OF DIFFERENTIAL COMMITMENT DURING THE VIETNAM WAR

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A nation at war, basing much of its military manpower on a system of conscription, offers the draftable young man several, usually limited, alternative choices.

Although the majority face their own moment of decision with some sense of resignation—to serve if called—some others choose a course of action which indicates a commitment either to a military life or to the kind of life and future that awaits the draft refuser.

During the Vietnam war a growing body of young men, especially on the college campuses, made the serious commitment to refuse military service. During that same period, however, and on those same campuses, another body of young men signed a contract obligating them to advanced ROTC training with the possibility of a commission in the U. S. Army. The focus of this study is upon those who have made these two rather different kinds of life-influencing, consequential commitments.

Early in 1968 a group of San Francisco attorneys established a legal panel to aid those young men who had committed themselves to actively resist the draft. From the slate of cases this panel sought to defend, we selected a sample of some 12 persons who had been indicted for their draft refusal. In roughly that same period of time, we also selected a group of 20 ROTC cadets from the University of California's military science program, all of whom were described by their colleagues as outstanding and as having a serious commitment to the ROTC.

The main purpose of the investigation was to gain access to the phenomenological world of these two groups. To that end, we personally interviewed individuals in both groups. Each interview took anywhere from two to seven hours. In addition, each person was individually administered a variety of tests. These included both projectives (e.g., TAT) and paper-and-pencil tests (e.g., ACL). Interviews were tape recorded and later transcribed. An edited case report was prepared for each person. These contained both biographical material and attitude-and-value-relevant data. Circumstances of testing prevented our administering precisely the same complete battery to persons in both samples; both groups, however, in addition to their extensive interview, received a set of TAT cards and completed the ACL.

Data which we have in common for both groups as well as data obtained on one but not the other were analyzed. Analyses primarily involved the careful examination of each person on a case-by-case basis. Further analyses sought comparisons of the groups as a whole both with each other and with the relevant data existing on other known (i.e. normative) groups. In all cases, our major effort was directed towards gaining sensitivity both to the uniqueness of the individual person as well as to the emerging themes which characterized the entire sample of draft refusers or ROTC cadets.

Preliminary findings from the test data indicate some of the anticipated differences between the two samples especially as regards motivation, stability, intellectual disposition, and what may be termed "preference for order and routine." Relative to normative groups, for example, the ROTC cadets do not appear to be highly intellectually disposed or intellectually mature. Self-descriptions (ACL) which differentiated the two samples of this study indicated the more generally idealistic, nonconventional, and individualistic perspective of the draft refuser

as compared with the more conventional, methodical, and practical view of the ROTC cadet.

Case history and projective material were used to obtain entry into the underlying processes, characteristics, and qualities of the members of each sample; these analyses have revealed several additional findings of importance. Those relating to family relationships and identifications, relationships with authority and attitudes toward intimacy, defensiveness, impulse control, and overall emotional expressiveness are of particular relevance and are discussed more fully.

MILITARY SERVICE AND AMERICAN YOUTH: SOME REFLECTIONS AFTER 17 YEARS OF PSYCHOLOGICAL EVALUATION OF NAVY AND MARINE CORPS RECRUITS

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The function of the psychiatrist and psychologist in the Navy and Marine Corps has evolved considerably over the past 17 years. It took only 20 years after World War II to learn that psychiatric case-finding methods were ineffective in recruit training, and that the mental health referral concept was appropriate. Psychiatry had been oversold, and psychiatrists and their ilk have had trouble shedding the expectation of omniscient ability to define a good military recruit or military leader. A review of seven years of research and experience at the Marine Corps Recruit Depot, Parris Island, South Carolina, may strip away some romantic impressions and cast the harsh light of reality on this sector of the American culture.

The theory of cognitive dissonance may permit comprehension of the intense esprit de corps in the Marine Corps. In order to justify to himself the severe initiation of recruit training, the Marine recruit has to assign high value to the group joined (or devalue the harshness of training). Further, the high incidence of school dropout and broken homes among those who enlist for a Marine career encourages a now-or-never attitude. Despite the presumed revision of Marine training after the 1956 drownings and the development of sophisticated physical complaints such as sling palsy and stress fracture, today's DI (Drill Instructor) still rules by fear and physical harassment.

A successful Marine DI builds his platoon's spirit by destroying civilian personality attributes and rebuilding individuals into a tight, interdependent unit with complete loyalty to the DI. This desirable result, however, makes it remarkably difficult to gather evidence when the official prohibition against physical maltreatment is broken. Further, subtle communication acknowledges the covert acceptance of physical brutality in training. Nevertheless an estimated 11% of all DI's are relieved from duty each year for proven maltreatment or closely associated offenses. Attempts by psychiatric personnel to predict which DI's

would be relieved from duty for maltreatment or other reasons have been proven entirely unsuccessful, yet the Marine Corps persisted in demanding the psychiatric stamp of approval on DI candidates.

As the Vietnam war draws hopefully to its tortured close, new evaluation of military service and the draft will be in order. Consideration of the anachronistic aspects of the Marine Corps suggests that the harsh, sadistic elements of training serve only to institutionalize violence in our culture and are not necessary to national defense. Further, excessive geographical mobility and excessively rigid discipline in the Marine family tend to effect a recapitulation of hyperaggressive behavior in the next generation. The anti-intellectualism inherent in the grossly physical character of training may be counterproductive in today's computerized world.

These negative comments should not obscure the very real advances in the military in the fields of physical fitness, desegregation, equal opportunity, and civil liberties. A strict authoritarian structured organization permits appropriate channeling of excess hostile aggressive behavior and satisfies the needs of youth for order, self-control, pride, and accomplishment.

ARMY BASIC TRAINING AS A GROUP PHENOMENON

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Army basic training is a remarkably successful (from the Army's point of view), nearly universal experience for the male in our society. It would be difficult to find any effort in our society which matches basic training's success in performing its "mission" of taking raw youth and turning them into "soldier-men." This paper examines some of the group principles employed by the cadre in achieving that result. The cadre has developed, without a formal attempt to utilize the psychodynamics of groups, techniques remarkably similar to those described for utilization in group therapy. The experience also has parallel with primitive puberty rites and rites of passage. In addition, there are some interesting similarities of technique in basic training with techniques of "brainwashing."

The methodology of the study consists of observations made by the author during the course of two years in which he served as the psychiatrist for basic training in a large Army training center. He became personally acquainted, in depth, with many of the training companies, their cadre, men, and methods.

The comparisons demonstrate the validity of some of the psychodynamic principles which have been described for groups. The success of the technique under such field conditions, relatively isolated from infusion of mental health principles, represents a further validation of what is known regarding the dynamics and functioning of groups. The relatively independent evolution of the methods used by the cadre is based on years of trial and error experience. The cadre use

with great skill the dimensions of group experience, described by Le Bon and Freud, of group invincibility, contagion, and suggestibility. They effectively infuse the group with a strong desire to come into "manhood" by successfully completing their training. The system utilizes many methods to increase the effectiveness of the group development. Some of these methods can be compared with some "brainwashing" techniques such as the utilization of physical fatigue, (realistic) threats of physical danger, development of nervous tension and anxiety, prolonged stress, rhythmic drumming and chanting, and offering as the only hope for survival and self-esteem joining the group and giving all you have to learning to protect yourself and your buddies by becoming a good soldier.

Considering the success and effectiveness of the techniques employed in military basic training, considering the universality of this experience for the male youth of this country, it behooves us to examine to what end, to serve what value system, to render what effect on man's mental health is this successful technique employed?

TIME AS A DETERMINANT OF BEHAVIOR IN A COMBAT ZONE

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The tour in Vietnam is a time-limited one of 12 months duration. From the moment of arrival, the soldier titrates his existence to the anticipated date of departure. As a result, temporal barriers are constructed which wall-off present experience from both the past and the future. In spite of this encapsulation, there is an inexorable reality to life in the combat zone that intrudes with a forcefulness to which each man responds. In the responses of individuals, however, time-related behavioral patterns can be discerned. In the present paper, we shall examine these phasic patterns in some detail with the aim of facilitating understanding of both their nature and their determinants. To accomplish this aim, we have studied 200 consecutive referrals to the psychiatric service of an evacuation hospital in RVN and counterpointed this with observations of non-patient behavior in the combat zone. Space does not permit more than a brief summary of the results.

Upon arrival in Vietnam, the soldier feels as though he has been plunged into a morass of newness which not only exposes his basic mortality, but also calls into question many of the transcendent values that characterized the societal matrix from whence he had come. This occurs in a setting where an individual is set apart from the dominant culture by virtue of race and language and also separated from people who had previously been objects of support and nurturance. Many of the basic assumptions governing his attitudes, behaviors, and expectations now appear either irrelevant or meaningless. As a result, he experiences a sense of dislocation to

which he responds by attempting to develop a new set of behaviors more relevant to his current life situation. Thus the task during the first three months of the tour is largely an orienting one. The majority of psychiatric casualties during this period have been unable to meet the orienting demands of this period which we call the dislocative phase. The magnitude of the demands are reflected: (1) in the casualty rate for this period—46% of the patients studied were seen during the first three months of the tour; and, (2) in the absence of indicators of significant psycho-social maladaptation prior to the combat tour.

Once the soldier has been able to negotiate the demands imposed by the dislocative phase of the tour, he then finds himself absorbed in the task of defining and participating in a new social order tailored for meeting the particular needs generated by life in the combat zone. This task is a dominant one from the fourth to the tenth month of the tour. The evolving system is founded upon present comfort and emphasizes self which has led us to call this the phase of the hedonistic pseudo-community. It is an informal system and at times comes into conflict with the military hierarchy. Psychiatric casualties during this time are generally: (1) individuals who have either been extruded or excluded from the community; and, (2) members of community whose primary allegiance to this informal social system has brought them into conflict with the established authority of command.

In the last two months of the tour, however, there is a visible shift in the focus of attention and goals of the men. They speak of home with an immediacy that had been lacking and are very much future-oriented. The task at hand is considered one of disengagement. The phase of detente has begun. Psychiatric casualties are minimal during this period. They exhibit either: (1) an inability to disengage (the bonds forged during the preceding months now tie them to the community and its various members; loosening these bonds generates a good deal of ambivalence); (2) an enormous anxiety about returning to a world which for some seems a less happy and more frightening alternative to the present; or, (3) a fear of being injured or killed during these last weeks after having managed to survive intact for so long a time.

The three phases of the combat tour, that of dislocation, the hedonistic pseudo-community and detente, each present the soldier with a set of specific tasks. Here, we have briefly defined the nature of those tasks and outlined some reasons for failure. What remains to be done is to examine in greater detail the phasic determinants and characteristics of the maladaptive versus the adaptive behavioral sequences.

THE BEHAVIORAL SCIENCES AND THE FEDERAL GOVERNMENT

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Consideration of the nature of the issues and problems involved in interactions between the behavioral sciences and the Federal government. Focus is on the bearing of the sciences—and in particular the role of the social sciences—in the formation of public policies, their implementation and assessment; the utilization of the social and behavioral sciences (central concern of the National Science Foundation Special Commission on the Social Sciences); and problems of educating and training “applied” social and behavioral scientists.

VIOLENCE AND IT'S REGULATION: HOW DO CHILDREN LEARN TO GOVERN THEIR OWN VIOLENT IMPULSES?

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Cross-cultural comparisons can place our understanding of violence in a wider setting. This paper is based specifically upon field investigations in Pacific societies between 1925 and 1967. Anthropological methods of participant observation, cross-sectional and longitudinal studies, detailed film and still photographic studies of relevant behavior—temper tantrums, attacks on the self during trance, destruction of property in the course of quarrels, sanctions carried out against those who deviate from expected standards—were all employed in the studies. These will be discussed together with published materials on cases of pathological homicide, contemporary situations on campuses and ghettos in the United States, and large-scale occurrences in which mass violence has occurred—the partition of India and Pakistan, the large-scale massacres which have occurred in Indonesia.

Violence will be defined as behavior designed to damage persons, property, or institutions which constitutes a break in expected and sanctioned behavior and is experienced by other members of the same culture as a positive violation of culturally patterned interpersonal behavioral norms. The term violence will not be applied to behavior which is regularly expected and sanctioned, such as warfare within the bounds of currently accepted rules of international law, capital punishment, corporal punishment, demolition or destruction of the property of

and individual by the state or the community, destruction of own property, self-mutilation, suicide, abortion, infanticide, etc., however violent these behaviors may appear to members of other societies, other periods, or even other classes or regions within a single society. An alternative approach is to lump every act which results in some possible damage, from spanking a child to bombing a city, as violence. Although this latter usage is more frequent, I do not believe it is more helpful.

In most societies, in events where there is a likelihood of overstepping customary and sanctioned bounds—large ceremonies containing elements of mock opposition, competitive group sports, parades, demonstrations—it is the young who are likely to take the most active part and to become involved in behavior which is unsanctioned and outside the limits of that particular society. In most societies, but not in all, elders are afraid of youthful impetuosity and lack of impulse control. Occasionally, as among such widely separated groups as the Arapesh of New Guinea and the Norwegians, the young may fear the unleashed impulsiveness of their elders. In the U. S. at present, trends towards youthful precocity in all respects has led to greater proportions of crimes among juveniles, so that youth are often feared as members of identifiable minorities.

Each culture has definite methods through which children learn what destructive and aggressive behaviors are impermissible violence and what behaviors are permissible. "You may hit boys but not girls." Do not hit below the belt." "Don't hit a man when he is down." These are examples of the admonitions given to small boys which define both that you can hit, and in hitting do damage, and that there are certain forms of hitting which are disallowed and will be disapproved and punished. In culture contact situations and situations of very rapid change, the types of impulse control learned in childhood, and the signals which indicate that an occasion is now intolerable and the old controls need not hold, become that confused. This is particularly true when members of different cultures are involved. Furthermore, in large urbanized countries an increasing number of children grow up with inaberrant learning situations and become potentially violent or potentially provocative of violence in others.

It is necessary to recognize that nonviolence as a political technique includes provocation, and that cultural training includes rules about the nature of the provocative behavior stimulus as well as about permitted responses. Training which outlines insults which may not be given accompanies training for controlling the impulse to retaliate and hurt. In our own culture, the treatment of animals is used to teach children when killing and giving pain is and is not legitimate towards animals and indirectly towards human beings.

In complex societies with a long history and a written legal system, prohibition of types of violence which have occurred in the past and might occur again become identified as misdemeanors and crimes. The very presence of the interdictions, of course, outlines to the growing child destructive acts which he might perform, in addition to the catalogue of destructive acts which he may not perform. Today the catalogue of possible offenses is supplemented by the collusion of the mass

media in celebrating every sort of violence, including putting the picture of the murderer of the President of the United States on the cover of a national magazine and permitting his mother to rejoice in his deed on television. Publicity becomes a sort of sanction within which violent behavior previously forbidden is expected. This effectively undercuts the education of children in which they were taught to control socially unacceptable impulses.

On the world scene, there is increasing evidence that there may be a negative correlation between the amount of experience in childhood with aggressive behavior that falls short of serious damage and the amount of violence that may erupt in that society. Those societies where children receive no training in limited conflict with others have the least experience in halting destruction and killing once it starts. The disturbances at the time of partition of India and Pakistan, and the more recent disturbances in both countries after the failure of the Communist coup in Indonesia, illustrate this. They suggest that opportunities for children to engage in mock and partial destructive behavior, which is then carefully limited and controlled, may be the best way to ensure that they will not, as adults, engage in riots and massacres.

VIOLENCE AND THE PHENOMENON

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If the history of thought may be read as an ongoing effort at self-revelation involving a series of ladders—linguistic, epistemological, moral—that, like Wittgenstein's, have to be climbed and then thrown away, then we may be ready to understand and transcend "violence" by revealing it for what it is from the point of view of an existentialist ontology of the phenomenon.

From an attempt to define "violence" in the broadest sense possible and thereby delineate the terms within the definition that are in need of further elucidation, the concept of "personhood" is singled out for phenomenological elaboration. The revelation of "personhood" as itself a thoroughly violating, appropriating, and destructive human phenomenon within the total phenomenon makes possible a tripartite and heuristic distinction: ontological, emotional, and physical violence.

This distinction reveals our current concern with physical violence as an evasion behind which we can hide the identity and self-permanence that constitutes the value and essence and evil we are determined to be. The phenomenology of violence reveals that violence exists as an all-important, determined, and terrifyingly significant and fundamental ground for our identity. We can begin then by accepting that as fact. But the meaning of that is far from the attribution of violence to biological substrate, an instinct, an inherent tendency. Such explanations are also evasions designed to justify our avoidance of universal responsibility.

Progress toward the elimination of the physical manifestations of violence depends first and foremost on our learning and exposing such societal evasions and our own self-deception.

Our distinction throws further light on current and past psychological, biological, and sociological explanations for physical violence. It exposes them also as evasions. All other emotional conflict problems must be approached from the same attitude: racism, religious prejudice, and sexual strife to name a few. Until we learn to admit and live constantly with the fact that we commit violence against ourselves and others everyday, until we learn to admit that we are all racists, until we learn that we are all religious bigots, and until we learn to admit that all men and women are ontologically opposed, we will make little progress toward the elimination of physical violence. Transcending this bad faith, this self-deception, is a primary requisite for the beginning of the end of rape, injury, murder, and war. It will hopefully be the beginning of the beginning of universal responsibility.

Along the way a point of view from which our puzzling cultural repression, the paradox of societally imposed sexual inhibition, the lamentable scarcity of love, the institutionalized violence that engenders war may be understood. We shall also develop a critique of some contemporary misunderstandings of human violence—Fromm and Storr—in the hope that a further distinction between healthy and unhealthy emotional conflicts may be justified. Only if ways can be suggested for the elimination of unhealthy emotional conflicts through recommended changes in the family and the educational practices in our society can physical violence eventually become a rare phenomenon.

The recent courageous and magnificent effort of the young to make us see that these changes are crucial should be encouraged; however, their growing refusal to violate, appropriate, and destroy (the blacks are a special problem) is somewhat misguided in that they are only choosing an unhealthy emotional violence in preference to physical violence. They are therefore merely caught in a different trap. They are pressing us to make a greater effort at self-revelation and understanding than has ever before been possible. We must, for their sake and for the children of the future, rise to the challenge.

VIOLENCE AND ALTERNATIVES

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A sidelight on the debate about violence as innate or learned may be provided by reference to a unique demonstration involving police and family crises. Students of suicide prevention have observed that the would-be suicide sees no other way.

Suicides are prevented when alternatives are presented. Similarly, if violence is seen as the expression of emotional bankruptcy, the possibility of alternative responses makes violence irrelevant.

Police have traditionally been called upon, as part of their peace-keeping function, to intervene in family disputes when violence threatens. The traditional response of police to such family fight calls is to restore the peace by putting the fear of the law on the unruly disputants. By thus meeting violence with repression, police are often caught up in the flaring hostility. As a result, police intervention not infrequently fails to prevent violent outcomes. Police themselves are among those seriously injured or killed as an outgrowth of intrafamilial aggression.

A training program for police family crisis intervention is currently demonstrating that when properly approached, police are receptive to alternatives to meeting hostility with aggression. There have been no violent outcomes from the inception of this program (to this writing). One of the techniques employed by the police in this demonstration is to hold out alternatives to violence to those involved in family disputes. The possibility is raised that nonviolent methods of conflict resolution may, in turn, be provided for children in these households. To the extent that such role-modeling is crucial in determining aggressive modes of response, we would expect children who are shown alternatives to be less violent.

POLICE AND THE MENTAL HEALTH OF THE COMMUNITY

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The law enforcement practices of a community are related to its mental health. The degree of conflict and contradiction between the human values of a society and the law enforcement enterprise it will support may be taken as an index of its emotional well-being. To the extent that a society which professes concern for human dignity permits less than humane practices by its law enforcement agencies, that society is "sick." Just as an individual can project his unacceptable and contradictory attitudes, a community can project unacceptable motives, use its police to act out for it, and then renounce its agents as brutal and sadistic. Thus police are in the position of being subjected to conflicting and contradictory demands. They are acutely aware of being pulled in opposite directions, vulnerable to criticism from one or another quarter. Their responses are predictable. They fall back on themselves, alienated and distrustful. Prevailing attitudes are cynical and depressed.

In their turn, police exert important influences on the emotional climate of the community. Minority groups respond to police attitudes of cynicism and social distance with reciprocal feelings, contributing to high levels of suspiciousness and distrust. Self-regard as well as attitudes toward the rest of society are pro-

foundly affected by the presence among ghetto residents of these most visible representatives of the majority. It is not sufficiently understood that police are not just distant symbols. They are called upon to intervene when family conflicts threaten to erupt into violence. In so doing, their presence may have profound implications for family relationships and mental health. Police are also called upon to deal with the emotionally disturbed, disoriented, or suicidal. Police are carriers of the values of a society, custodians of its mental health as well as its property.

The experience of the Police Family Crisis Intervention Project jointly undertaken by the New York City Police and the City University of New York supports the basic contention of this paper. Performance of a routine police function—family crisis intervention—can be consistent with the humane values and community mental health. Approached with understanding and respect for the difficulty of their community role, police can be open and responsive to social demands for compassionate and constructive performance. The police involved show enthusiasm and high morale, and community response has been positive.

CAN WE LEARN TO GOVERN?

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We know this side of "the great transition" (K. Boulding). In "creating" it, we have successfully dealt with the question of productivity. This has been a central and decisive human achievement. Unhappily, we are engulfed by the stunning fulfillment of this central national purpose. The deeply felt inadequacy of this success has disoriented us.

Education simply mirrors this disorientation. It has faithfully fulfilled its mission in producing the producers on all levels. The best *products* of our schools, honed by increasingly keen competition, enter college in greater numbers (note the spectacular increase in Gross School Product), better prepared to do what universities want them to do. This success, too, is plainly inadequate.

The unfolding "side" of the great transition will be determined by how we govern the mindless, wildly running machine of production. Hopefully there are strong enough currents in our democratic traditions to facilitate a transformation from our ethos of production to an ethos of community—from an emphasis on turning out products to an emphasis on the education of citizens.

Education has been inhibited in its growth to maturity by the narrowness of national purpose. It can attain maturity as it participates in the transformation of this purpose. It has induced in our young the will to work, to become producers. It can induce in the young the will to govern, to become fuller citizens as prelude to becoming fuller persons.

To fulfill this mission we must search for a "process whereby the majority of the people can alter their beliefs freely and spontaneously [without unduly threatening] the stability of the community" (F. Hoyle). This conception can be applied to public education, particularly in urban centers.

I will suggest such a process. Its potential for evoking in those involved the will to govern and for developing the skills needed to govern effectively will be examined. Fortunately, this frightful period of transition also facilitates the invention of systems capable of "fix[ing] experience more nimbly . . . evolving the ability to evolve . . . [and] learning to learn" (R. W. Gerard). Can we be somewhat optimistic about man using his considerable biological potential to become a benign dweller on earth? I draw a sustaining degree of faith from the dialectical retort made by a student in heated rebuttal to her cool, cynical friend: "You know, people are *much* better than they are."

THE DELINQUENT AND INSANE: RIGHT AND ADEQUACY OF TREATMENT

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Compulsory treatment measures are applied to two main deviant groups in the United States: (1) youths sentenced to some type of correctional facility when adjudicated delinquent under various criteria, and (2) persons statutorily committed to a hospital subsequent to a criminal act for which they have been found not culpable due to legal insanity. Both raise questions pertaining to the basis and purpose for ongoing detention. If a person is detained under these circumstances is there a "right to treatment"? If so, is there a subsequent right to some standard or norm for "adequacy of treatment"? Should treatment actually be considered as the primary goal, or is it in fact public protection against people considered socially opprobrious or "dangerous"?

Differences arise between social, legal, and mental health groups in determining who should evaluate the "treaters" and the programs they direct. Difficulties in determining the criteria to be employed in determining the adequacy of treatment are discussed. The issue of "dangerousness" permeates much of the discussion about detention of individuals who may be considered mentally ill as well as criminally dangerous ("mad and bad"). The problem pertaining to prediction of dangerousness is crucial to this discussion.

An increasing number of issues are expected to arise to test the vague criteria currently employed as well as the basis for making decisions. Confusion is present not only because of the lack of adequate treatment facilities and personnel, but in the very nature of what constitutes treatment and how it should be determined.

It is believed that determination of treatment adequacy will no longer be left in the hands of the individual or group administering treatment, and a long process of establishing standards via the judicial or a quasijudicial approach will commence.

GEOGRAPHICAL FLIGHT AND ITS RELATION TO CRISIS THEORY

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A significant percentage of people in the nation are in motion as a result of discomfiture. They are seeking resolution of their tension in movement itself. The most extreme form of this behavior and the only one that has been the subject of any study is the chronic wanderer—the classic “homeless man.”

Travelers Aid's across the country, and notably in the Nation's Capital, sees this phenomenon of fleeing both in its chronic form and before it has become a chronic, imbedded way of life. Those who come to the attention of Travelers Aid are not only fleeing from some crisis in their earlier circumstances but tend to be in further crisis because the flight is interrupted. For this compounded crisis phenomena the writers have coined the term “crisis flight,” which appears to be a unique extension of the existing crisis theory. This paper will elaborate on this concept to indicate areas which warrant further study to extend understanding of the phenomenon and to seek guidelines for treatment.

Intervention in crisis flight has some peculiar components that are not found in other types of crisis intervention, even though it may fall within the basic design of crisis theory. One component is that the client who appears for help sees any service other than aid for continued flight as intrusive to his coping mechanism of disequilibrium. Preliminary studies of intake in Travelers Aid, Washington, D.C. reveal that an increasing percentage of clients use the disequilibrium of movingness as their preferred adaptive state. The writers have hazarded some guesses as to the psychodynamic etiology of the significance of disequilibrium for this group.

A second component peculiar to this crisis-flight group is that frequently the caseworker must work without knowledge or sufficient information to formulate a psychosocial diagnosis because the client is either unable or unwilling to supply even the most minimal information about himself. This includes unwillingness or inability to give his name, where he came from, why he came to the city he is in, and what he wants. A dilemma is created for the caseworker in this circumstance since it is impossible to apply existing crisis-intervention theory in cases where elementary facts about the client's circumstances and personality makeup are unknown.

Obviously, there is urgent need for research to examine this whole area in disciplined detail, realizing that it is a largely unrecognized mental health problem with a dearth of literature on the subject.

This need for research is heightened by the trend toward open hospitals and the emphasis of outpatient treatment facilities and by the increased mobility with continued legislative restrictions against nonresidents.

In order to create opportunity for such research, the writers are proposing the establishment of a paramedical facility which will permit evaluation of the crisis-flight theory and test out its parameters. In addition, this facility may become an effective treatment modality which will allow intervention in the client's long series of negatively resolved crises.

A STUDY OF THE CHILD CARE ATTITUDES OF TWO GENERATIONS

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Although it has been maintained that the nuclear family has become isolated from the extended family in our industrial society, clinical reports have indicated that mothers of young children continue to be involved in complex and ambivalent relationships with their own mothers. Many women live with their own mothers for some time after marriage and, even in those cases where the mother lives some distance away from her own mother, the automobile, telephone, and other forms of rapid transportation and communication make it possible for the two generations to maintain close contact. The present study concerns the relationship between the two generations regarding child care attitudes and, in addition, seeks to determine the differences in the child care attitudes of the two generations where mothers and grandmothers share a common household or elect to live apart.

Method: Ninety mother-grandmother pairs, recruited via newspaper advertisements, were administered the Maternal Attitude Scale. This 233 item Likert-type questionnaire yields five summary factors which assess child care attitudes regarding the following issues: (1) modulated control of the child's expression of his aggressive impulses, (2) development of a reciprocal mother-child relationship, (3) attainment of an appropriate degree of closeness between mother and child, (4) recognition and acceptance of ambivalent feelings regarding child care, and (5) perception and satisfaction of the infant's physical needs. All subjects also completed a family information form which provided data regarding socioeconomic status, household composition, and frequency of visit between mother and grandmother.

Results: The child care attitudes of mothers were compared both with those of their own mothers and with those of other mothers from their own generation who were matched on relevant background characteristics. Significant intergenerational relationships obtained between mothers and their own mothers regarding three of the five factors: (1) inappropriate versus appropriate control of the child's impulses ($p=.01$); (2) discouragement versus encouragement of reciprocity ($p=.01$); and (3) comfort versus discomfort in meeting the baby's needs ($p=.01$). In the case of each of these three factors, the child care attitudes of mothers were significantly more closely related to those of their own mothers than to those of other mothers in their own generation.

Mothers were classified as sharing a common household with their own mothers if, at the time of the study, the two generations lived at the same address. While a number of women had lived with their own mothers at some time following marriage, only 17% of the mothers were living with their own mothers at the time of the study. There were no significant differences in relevant background characteristics between either mothers or grandmothers living together or apart. However, mothers sharing a common household with their own mothers indicated more maladaptive attitudes than mothers living apart regarding the factor of inappropriate versus appropriate closeness with the child ($t=2.60$, $p=.01$). This same finding also obtained for the factor of inappropriate closeness in the case of grandmothers living with their own daughters or living apart ($t=2.33$, $p=.02$). Mothers living with their own mothers showed more maladaptive attitudes, although the differences were not significant, regarding each of the other four factors; this pattern of differences concerning the four other factors did not obtain when comparing grandmothers living together with their daughters and grandmothers living apart.

The findings from the present study suggest that grandmothers do continue to influence their daughter's child care attitudes and that more intensive study of the mother-grandmother relationship is necessary.

MOTHER-CHILD ATTACHMENT PATTERNS: COMPARISONS BETWEEN A GROUP WITH EARLY DAY CARE EXPERIENCE AND A HOME-REARED GROUP

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In the search for new models of environmental situations conducive to optimal growth, the "whole child" must be taken into consideration. For the past few years most innovative programs concerned with young children have appeared to assign a higher priority to cognitive development than to emotional and social development. Undoubtedly they have not done so in actuality, but the higher visibility of the cognitive input and the greater ease of measurement of the cognitive variables contribute to the appearance of imbalance of objectives.

Any new model of a child care supplement which hopes to gain public acceptance must present evidence that it does no damage to the children in any area of development, regardless of whether it enriches or supports in some particular area. The present paper discusses attempts to determine whether a group of infants and toddlers enrolled in a day care center offering cognitive enrichment showed deviant social and emotional development at 2½ years of age.

Subjects for the study were 23 home-reared children and their mothers and 18 day care children and their mothers. At the time of data collection, all children were between 30 and 36 months of age, and the day care children had attended the child care center for at least one year. Data consisted of ratings made

from lengthy tape-recorded interviews with the mother conducted by the project social worker and rated by the interviewer plus one additional person. For data analysis, consensus ratings of the two persons were used. Nine-point rating scales were developed, covering such areas as affiliativeness, nurturance, compliance, adaptability, and general emotionality of both the mothers and the children. Between-group differences were analyzed by means of the *t* test.

Results revealed few if any significant differences between the home-reared and day care center children in their interpersonal behavior with the mothers and in terms of general emotional behavior. A weakening of the mother-child attachment, to which the investigators in the study had been alert and which some persons had feared, was not observed in the children. It was concluded that normal mother-child interaction and emotional development are not necessarily precluded by early day care experience.

THE EFFECTS OF THREE KINDS OF PERCEPTUAL-SOCIAL STIMULATION ON THE DEVELOPMENT OF INSTITUTIONALIZED INFANTS

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Developmental psychologists agree on the necessity for stimulation of infants raised in an institutional setting, but the kind of stimulation needed remains a controversial question. Casler, in his critical review of the literature on material deprivation, emphasizes the concept of perceptual deprivation. He believes that the developmental impairment shown by institutionalized infants less than 6 months old are usually due to other factors than the lack of a mother. His findings, like those of White and Held, show that an increase in sensorimotor stimulation results in a marked improvement of certain areas of development, even in very young infants.

Most of the stimulation (visual, tactile, etc.) used in these studies are given through a human agent (the nurse, the experimenter) so that the effects of the presence of the human person cannot be isolated from the enrichment in the perceptual environment. Consequently, it is unclear how much of the resulting benefits are attributable to the unusual "social" relationship rather than to the variable itself.

With the aim of shedding some light on this important issue, the following experimental design was used:

Sample: In a traditional institution, 48 infants of both sexes were equally divided into four groups (three experimental and one control group) and for a period of three months 36 of them were submitted daily to three main types of stimulation. The infants were 2½ months at the onset of the experimentation. When they reached 5½ months, stimulation were ceased. A final reevaluation was done one month after the end of the period of stimulation.

Experimental Group A: For 15 min. daily the subjects in this group received certain kinds of perceptual stimulation without the intervention of the human person. The stimulation was of four main types—tactile, visual, auditive, and kinesthetic.

Experimental Group B: The subjects in this group received extra stimulation through increased human contact but without the use of inanimate objects. An experimenter was assigned to each infant and following a standardized procedure did some "mothering" during 15 min. each day.

Experimental Group C: The subjects in this mixed group received daily 7 min. 30 sec. of the nonhuman stimulation of group A and 7 min. 30 sec. of the human stimulation of group B.

Control Group: The subjects in this group received no supplementary stimulation but were designated to the staff as research subjects.

Evaluation Techniques: (1) The Griffiths Mental Development Scale, (2) two scales of object concept based on Piaget's theory, (3) a series of standardized observations, and (4) a movement transducer: the electrograft. The infants were tested at the onset of the experimentation and every six weeks thereafter.

Preliminary Results (the experimentation proper ended in mid-October 1968 and the analysis of the data is far from completed; the following *preliminary* results still need verifications): (1) Contrary to the view frequently encountered, gross motricity is affected by institutionalization as early as 3–4 months. (2) Hearing and speech remain impaired in spite of the different stimulations offered. (3) There exists some significant differences between the groups. (4) The discrepancy of the stages reached in the two Piagetian scales confirms previous findings (Saint-Pierre, Décarie, Brossard).

COGNITIVE GROWTH IN PRESCHOOLERS THROUGH STIMULATION OF VERBAL INTERACTION WITH MOTHERS

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The Verbal Interaction Project was an investigation of the effects on the verbal and cognitive growth of low-income preschool children of a home-based, experimental cognitive enrichment program. The focus of the major experimental intervention was on the stimulation of verbal interaction between child and mother through encouragement of verbally oriented play activity around toys and books. Its long-range goal was to make the child's own mother the ultimate agent of intervention in his intellectual growth.

As in the pilot study (described in the article by Phyllis Levenstein and Robert Sunley, "Stimulation of Verbal Interaction between Disadvantaged Mothers and Children," *American Journal of Orthopsychiatry*, January 1968) an experimental design was followed. The 54 subject dyads were divided into three geographically

separated groups, all living in low-income public housing projects. An experimental group ($N=33$) was exposed to seven months of stimulation of verbal interaction in the dyads through home sessions focused around toys and books called "VISM" (Verbal Interaction Stimulus Materials). The home visits were made by experienced social case workers trained in the intervention techniques, who were titled "Toy Demonstrators" since their role was to model for the mothers the possibilities for effective verbal interaction inherent in the toys and books. One comparison group ($N=9$) was exposed to seven months of home visits without such stimulation, to provide for the Hawthorne effect. A second comparison group ($N=12$) was given no intervention beyond the standardized intelligence tests administered to all three groups before and after the intervention period.

After seven months of "double intervention" for the experimental group and of "single intervention" for the first comparison group, the mean general IQ gain of the experimental group was significantly higher than that of either comparison group. The mean verbal IQ gain of the experimental group was significantly higher than that of the first comparison group.

COGNITION AND ADAPTATION IN THE YOUNG CHILD

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This report will describe some interrelationships between cognitive, motor, and psychosocial aspects of the normal developmental process. Particular emphasis will be placed on the use of nine Piaget tests of cognitive structure designed by Laurendeau and Pinard to cover the preoperational/concrete operational period of cognitive development. The association of these tests with Wechsler IQ and with a score of motor development is reported in addition to their separate and combined predictive power with respect to achievement in the first three school years.

Finally, a preliminary attempt to explore the possibility of "noncognitive" contributions to the Piaget tests is outlined. This is a simple correlation analysis of the relationship between measures of emotional disturbance and the Piaget scores in the first three years of school.

This data was collected in the first three years of an ongoing investigation of 100 normal middle-class elementary school children. The aim was to trace the development or maldevelopment of learning skills from the kindergarten year by the yearly collection of data in the areas of cognition, motor and perceptual-motor skills, and emotional functioning. In the first two areas standard psychometric tests were given in the schools by trained psychologists and technicians, in addi-

tion to the Piaget tests. The emotional area was assessed by psychometric and questionnaire methods plus a clinical interview in the child's home carried out by a child psychiatrist and scored in a standardized manner. The 100 subjects were beginning their schooling in three Protestant public schools in one of the most homogeneous, English-speaking, middle-class areas of Montreal. Over 90% of the children attending the three schools were able to participate. The remaining 10% included those whose parents did not agree, those with IQ below 80, and those with obvious brain damage syndromes.

The results indicate that both the Lincoln Oseretszky and the Piaget tests may be better than the WISC for prediction of subsequent achievement from kindergarten testing. The WISC IQ and Piaget scores were quite closely related ($r=0.5$ in kindergarten, $r=0.6$ in first grade, $p<0.01$). The Lincoln and Piaget were only minimally and inconstantly correlated.

A composite derived from the best subtests of the Piaget and WISC and of the whole Lincoln battery gave correlations suggesting predictions as high as 0.80 for first grade and 0.74 for second grade achievement. However, these await verification on a second sample.

An initial attempt to assess whether motivational and affective factors were involved in the success of the Piaget measure was carried out by correlating the neuroticism scores derived from clinical interviews with the Piaget scores. The results suggest small but significant relationships between several of the subtests and total score and the neuroticism variable. This is in the direction of increasing neuroticism being associated with decreasing (more primitive) cognitive skills. The implications of these findings for dynamic theories of ego development are discussed, together with the relevance of Piaget's genetic development theories.

THERAPEUTIC STIMULATION FOR NEGLECTED CHILDREN

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Many neglected and abused children are apathetic, withdrawn, prone to trouble in school because they cannot cope with the behavioral requirements or academic work. These difficulties stem from psychological maldevelopment which is, in turn, the result of understimulation, neglect, or traumatic handling by parents. When the result of understimulation, neglect, or traumatic handling by parents is extreme it may be possible to remove the child from his bad environment and provide him with better. More often, the child must continue to live in his own home, because proof of neglect is not adequate to obtain a court order for placement. In these circumstances intervention on the child's behalf is

difficult and challenging; most often it is limited to vain attempts to "improve" the parents or their child care.

This paper describes a small pilot attempt to work directly with two young children who were seriously disturbed and retarded in their personality development because of negligent and inattentive handling at the hands of their own parents. Primary work was carried out by graduate nurse with experience in child care and a warm, empathic nature. Two goals were paramount: to stimulate and gratify the children in a variety of ways that were unavailable to them in their own homes, and at the same time to take care not to make their treatment a burden to their already overburdened parents and to avoid arousing the jealousy of parents and siblings because of the "treats" given to the patients.

The first goal was approached by almost daily contacts between nurse and children. Using the facilities donated by a local church as a base of operations, the children were taken swimming, to plays at the children's theatre, taught to identify colors and numbers, played with, read and sung to. The local YMCA permitted the nurse and children to join a weekly family-night program, and the children learned to use the trampoline, which they loved, and other gym equipment. Swimming, which consisted largely of the children being towed around the pool by the nurse, was a highly tactile and hugely enjoyed part of their experience. This part of the therapeutic program, which could properly be called "therapeutic stimulation," was almost at once a success. Symptom dropout began soon, as temper tantrums diminished, expressionless faces became animated, clinging, whining behavior gradually diminished and, in the child who had been on the verge of expulsion from school, school behavior and work improved.

The other goal, the parent appeasement, which we relied upon for our ability to hold the children in the program, was much less successful. One child's parents claimed to be unable to view as improvement their apathetic son's conversion into an animated, active, demanding youngster. Instead, they professed to view his former listless acceptance of his deprived life at home as being a "good child," and the new demands he made upon the environment as evidence that he was being "spoiled by all the attention." After four months they suddenly banned all contact with their child, to the great disappointment of our staff and the boy, and adamantly refused to change their minds. Although the other child stayed for the full six months of the original program, and for the summer's extra work preparatory to her (successful) reentry into school in the fall, our work with the family soon disclosed a depth of brutality and deprivation that our original contacts had not shown. Major social "surgery" was required to prevent the child and her eight siblings from having to be split up and institutionalized. A fight between the father and a teenaged son proved near fatal to both, and required the boy's removal from the home. Strong authoritarian handling was needed to prevent the father's continued abuse of his wife and children, and close supervision and gratification of the mother was necessary in order to hold her together and prevent her desertion of the family.

A NATIONWIDE SURVEY OF PHYSICAL ABUSE OF CHILDREN REPORTED THROUGH LEGAL CHANNELS

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This paper reports the method and findings of a nationwide study of physical abuse of children which is being conducted by Brandeis University for the Children's Bureau, Social and Rehabilitation Services, U. S. Department of Health, Education and Welfare. The purpose of the study is to examine: (1) incidence rates of child abuse in the U. S. population and selected subsegments of it; (2) characteristics of individuals and families involved in child abuse; (3) circumstances surrounding and precipitating incidents of child abuse, including data on injuries; (4) patterns of health, welfare, and legal intervention measures, and their effects. The study defines child abuse as "nonaccidental physical attack or injury, from minimal to fatal injury, inflicted upon children by persons caring for them."

Every incident of child abuse reported during 1967 and 1968 throughout the U. S. in accordance with reporting legislation in all the states is channeled to the study by means of central registries set up in 1966 in every state. Standardized precoded instruments are used to describe each incident and the individuals involved. Every incident occurring during 1967 in a representative sample of 38 cities and counties was subjected to a more intensive study and analysis by means of comprehensive, standardized, partially precoded research schedules.

Prior to the 1967 and 1968 nationwide surveys a pilot study was conducted in California, and a nationwide public opinion survey explored knowledge about and attitudes toward physical abuse of children and the adults involved in such incidents. Approximately 6,000 incidents were reported during 1967, and approximately 1,500 of these were reported from the sample communities and are thus included in the comprehensive analysis.

The findings of the study differ in important respects from findings of earlier clinically based and oriented studies. This difference in findings which will be presented in the paper leads to a sociocultural conceptualization of the phenomenon of physical abuse of children which is different from the now widely accepted conceptualization according to which abuse is the result of psychopathology on the part of the abusive caretaker. The difference in conceptualization leads also to different preventive approaches.

MENTAL ORGANIZATION AND MATERNAL ADEQUACY IN RURAL APPALACHIA

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An intensive study has been made of the mothers of 65 5-year-olds residing in rural Southern Appalachia. All children were attending OEO-sponsored day care centers for lower-income families. The overall assumption guiding the study was that if one takes a group of children from similar socioeconomic background, the level of care received by the child is a function of the degree of maturity evident in his mother's personality.

In this research, maternal intelligence was found to correlate with the child's at .35, despite sampling limitations and consequently constricted ranges of scores. We have sought to go beyond this not uncommon finding to some of its possible determinants. Specifically, this paper will focus on the chain of circumstances whereby the mother's mental organization determines the atmosphere, physical and psychological, in which the child lives, which may in turn affect his own cognitive and emotional growth.

The sample included virtually all mother-child pairs active with the service program which had reached out very actively to include all those eligible in one county. Nevertheless, the sample is biased slightly in the direction of geographically less mobile, less suspicious, and more accessible women. The instruments included:

1. The Childhood Level of Living Scale. This instrument was devised to objectify the notion "level of child care," and it permits discriminations regarding life style among families which all fall in the lower socioeconomic statuses. It was completed by our research social workers following a series of history-taking home visits to the mothers. Items in the scale have been combined rationally and empirically into a total of 21 subscales, ranging from State of Repair of the home, through Sleeping Arrangements, to Providing Reliable Evidences of Affection.

2. Psychometric examination. Both mother and child took a battery of standard psychological examinations, including the WAIS, Rorschach, and TAT for the mother and the Stanford-Binet for the child. Testing was done without knowledge of social history information, of course.

Median IQ for mothers on the WAIS was 78, similar to that obtained with comparable subjects in urban areas. Median for the children was within the normal range—94. Maternal IQ correlates negatively with age. Since WAIS is already corrected for age, it implies more rapid drop than in the standardizing population.

There is a very marked relationship between the general efficiency of the mother's intellectual functioning, as measured by IQ, and the Childhood Level of Living. 15 of 21 subscales show significant relationships to maternal IQ as predicted. Even within our constricted range, the children of mothers scoring less than Dull Normal experience a generally lower standard of child-caring.

Rorschach protocols were also scored for maturity of mental functioning. A

number of subscales were found significantly related to the absence of Functional Integration response: again, the greater maturity of integrative cognitions correlated with a higher standard of child-caring. TAT protocols were rated for the maturity of resolutions of conflicts described in stories. Primitive resolutions projected on the TAT related to primitive disciplinary tactics observed in the home; there was also evidence that use in TAT responses of the kinship term Mother, reflecting a "motherly" self-concept, correlates with standards of grooming and cleanliness.

In cases of nondeliberate neglect or marginal child-caring, the mother usually plays a fulcral role. Our data demonstrate concretely the dependence of the child's early fate on aspects of his mother's character structure. The implications for planning large-scale programs are discouraging of the efficacy of the superficial approaches thus far attempted.

FACILITATION OF MOURNING DURING CHILDHOOD

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Although death of a parent during childhood is generally considered a major threat to emotional development, surprisingly little systematic study has been given to alleviation of the pathologic consequences. Data on 18 untreated orphans, some with six-year followups, strongly confirm the severity of the threat.

Another series of 22 orphans and four sibling-bereaved children ages 4 through 14 treated at the Center for Preventive Psychiatry reveals much possibility for alleviating emotional problems associated with childhood bereavement. Facilitation of mourning is a crucial aspect.

Among the major factors required to facilitate mourning are: (1) Guidance of the surviving parent to assist the child's mourning, alleviate mutual incestuous temptations, and encourage healthy substitute objects for the mourning child's libidinal investment. (2) Cultivation of positive transference with contemplative therapeutic alliance. A considerable amount of affectively charged detailed remembering of the lost object is feasible among most bereaved children. Affects of sadness and rage appear in transference. (3) Diligent interpretation of transference separation reactions leading to insight and working through of prior reactions to parent death. (4) Genetic interpretation of connections between stage of development at bereavement time and fixation of certain ego functions and psychosexual levels to those then existing. Fixations to magical stages of thinking are feasible to work through when bereavement occurs in preschool years.

Three special areas of facilitation of mourning are detailed. One is the anticipatory or preventive management of children whose bereavements are predictable. A second special area is facilitation of healthy sexual identity development among

orphans. A third is facilitation of intellectual development when bereavement is associated with conflicted memory function.

Anticipatory or preventive management of childhood bereavement is exemplified by treatments of two relatively healthy sisters, ages 8 and 10, who were confronted by the impending and then actual death of their leukemic brother. Their therapy was oriented toward experiencing of sad affects, acceptance of the finiteness of life, and coping with the deprivation of maternal care during their brother's terminal months.

In regard to facilitation of healthy sexual identity development among orphans, of particular importance (but neglected in the literature) is assistance for maternally bereaved girls in solving their feminine identity problems. A 10-year-old girl who wished never to marry and had memory inhibitions as well as conversion symptoms was helped to remember her mother who had died five years earlier. Positive transference and reflective therapeutic alliance during one year of once-a-week treatment produced states of affectively charged mourning, with interpretable transference neurosis. As an apparent result of the work, there was distinct feminization of identity and a catching up to developmentally appropriate social relationships.

The area of learning inhibition associated with conflicted memory functions is exemplified by treatment of a 9-year-old boy whose father had died three and a half years prior. The painful, disruptive experiences of this period had been repressed and remembering itself became impaired with attrition of many memory-related educational tasks. In the setting of once-a-week treatment for nine months there was much expression of explosive fantasies, followed by increasing availability of affectively charged memories of his father and the frightening events associated with his father's death. School work improved, reading jumped two grade levels, and forgetting diminished.

The authors conclude that a considerable amount of mourning work, not qualitatively different from that of adults, can proceed in children with the assistance of psychotherapy. It is proposed that mourning need not be delayed until adolescence nor lurk as a staunchly defended against process which must then erupt in postponed depressions of adult life.

UNDERSTANDING THE STAGES OF A TYPICAL TEMPER TANTRUM

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The cursing, fighting, wild anger of a child is an alarming sight to the adult in charge of him. The destructiveness of a temper tantrum not only frightens adults but demands protective actions be taken by them. Being forced to take action and being at least mildly frightened is a troublesome combination. It is the kind of situation that produces many inappropriate ideas and nontherapeutic actions—ranging from gross oversimplifications of what is going on to actual counterattacks

on the child. This paper is an effort to complicate helpfully the view of a temper tantrum by presenting it as a series of ego conditions. It is largely based on observations of borderline psychotic and character-disordered boys (7-12 years of age) in residential treatment.

The temper tantrum is presented as a six-stage phenomena. Behavior description and therapeutic intervention for each stage are described. The ego conditions underlying the stages are analyzed.

1. In the first stage, *rumbling and grumbling*, the child's ego is crumbling under the burden of growing panic. Signal anxiety is either not available at all or unable to mobilize defenses and coping skills to deal with the mounting discomfort.

2. At the *help-help* stage the child externalizes the anxiety by doing something which alarms (signals) the adults around him. He does something forbidden as a signal indicating his need for help. With the arrival of adult control, the tantruming child struggles to maintain some sense of his own ego's efficacy, or at least identity, by a series of ego retrenchments.

3. *Either-or* covers mainly his efforts to maintain a sense of efficacy, some sense of causing events.

4. *No-no* is a retreat to a more primitive identity, but still maintains interpersonal contact.

5. In the *leave-me-alone* stage the retreat is from contact with others in an effort to maintain an even smaller "all-alone" me. The draining of outward aggressions and the increase of depression occur mainly in these last two stages.

6. The *hangover* discussion focuses on developing the child's awareness of what happened in the tantrum and our efforts at making alternative behavior more available to the child.

Seeing the temper tantrum as a series of different ego conditions promotes a more complex understanding of the child in the life-space and allows us to helpfully vary our management of the child. More understanding of tantrums diminishes the adult's fear of them and diminishes the power that the threat of a tantrum has of manipulating adults into untenable positions. Notions like the stages are conceptualized somewhere between the therapist's ego psychology and the child care worker's life-space management. Together the child care worker and the therapist can construct therapeutic interventions. Training and supervision of child care workers is aided by such life-space formulation of ego processes. Last of all, but most central, the child stands to gain a teacher and ally for his ego.

BEHAVIORAL OBSERVATIONS ON CHILDREN WITH MINOR PHYSICAL ILLNESS

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This paper reports on observations of behavioral changes in acutely ill children nursed at home by their mothers. The children's reactions to an illness, to its accompanying emotional stress, and to the response of the family were assessed. A total of 35 children (23 boys and 12 girls) between the ages of 2 and 4 were gathered from one pediatrician's practice which consisted of middle-class, stable families. Children with a chronic illness or a past hospital admission were excluded. The pediatrician determined the nature and severity of the illness (mostly upper respiratory infections and viral childhood diseases). A psychiatrist instructed the mothers in everyday observations of the sick child and completed the data regarding the child's reaction at a home visit during the child's convalescent period. The Vineland Social Maturity Scale and Anna Freud's concept of Developmental Lines were used to determine the child's maturity.

Among the findings were:

1. All children manifested marked behavioral changes during the acute phase of the illness primarily in ways of relating with their parents. Most common (22 patients) was a clinging, whiny behavior with heightened demands for the mother's constant presence and attention. A smaller group (9 children, all over 3 years of age) displayed a more self-contained, undemanding, "leave-me-alone" reaction, at times appearing withdrawn from their environment. The remaining 4 children showed characteristics of both major reactive groups.
2. No correlation was noted between behavioral reactions and such variables as the child's social quotient, the nature of the illness and its severity, and the medical regimen.
3. All 12 children observed during a second illness demonstrated the same regression behavior present during their first illness.
4. In addition to the changes in object relationships all children manifested other evidence of reduced ego-functioning; e.g., diminished control of motility and of speech, increased sleep and use of various comforters, and a recurrence of earlier rather specific fears (despite no evidence of delirious states). Children already toilet trained rarely showed a loss of sphincter control, but they frequently regressed in their beginning bodily independence, wanting more assistance from their mothers in the bathroom or with dressing and undressing.
5. Several anxious mothers conveyed their apprehension to their ill child, which resulted in a mutually heightened dependency on each other.
6. The convalescent phase was mostly characterized by a demanding, impatient behavior together with a decreased frustration tolerance and impulse control. This change was particularly striking in the, while acutely ill, undemanding children, who resumed interaction with the family in a controlling, angry, yet apprehensive way as if they had undergone a separation experience.

7. No lasting regressive functioning was noticed, and within two weeks all children had regained their pre-illness adaptational levels.

In addition to documenting characteristic behavioral changes in a group of ill children treated at home, the study illustrates the importance of a reassuring and verbalizing pediatrician-mother-child relationship for the child's successful coping with an illness and the attendant emotional stress.

THE MOTHER WHO GOES FROM DOCTOR TO DOCTOR WITH HER CHILD

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A mother may take her child from doctor to doctor for many reasons. The chain of events commonly goes as follows: A woman who is not sure of her adequacy as a mother has her feeling boosted by events in her life and develops the belief that something is wrong with her. She may be unable to tolerate the overwhelming anxiety this provokes, and she projects the defect onto her offspring by initiating a self-fulfilling prophecy. She begins to think he is abnormal, gradually makes a diagnosis, and begins gathering "proof" from physicians, school personnel, and any source that will support her diagnosis. Mother exaggerates symptoms or manufactures them and is very fond of her child's physician if he goes along with her. If he doesn't agree with her, she is likely to go from doctor to doctor until she finds one who does. Then, with good conscience, she treats the child as if he had the projected defect, and he indeed becomes sick. Mother denies her own problem, meets her own needs in pathological ways, and cripples her offspring. The diagnosis is confirmed, the prophecy is fulfilled—we have a sick child. Life becomes centered around this pathological way of living. But mother's projection sometimes boomerangs. The child may become very ill so that even his life is threatened; or the threshold of mother's emotional strength is challenged or exceeded.

A multiple-view history taken from mother, father, child, and teacher, correlated with a thorough physical examination, will clarify the dynamics and increase the chances of successful therapy. The situation demands a sensitive, empathetic, patient therapist who can form a nonthreatening relationship, become important and significant to mother, and immune to her usual testing maneuvers. Premature advice or exploration of dynamics too soon, though the formulation may seem obvious, usually causes the mother to seek other professional help.

Commonly, the mother attempts to initiate a second self-fulfilling prophecy on the doctor. She says to herself: "This doctor is not reliable. He doesn't know what he is doing." When the doctor doesn't agree with the diagnosis she has made, she challenges and provokes anxiety within him. He may then defend himself by becoming uninterested, abrupt, or authoritarian. At this point it is wise to examine

the process and use knowledge and therapeutic skill rather than get tangled up in the content. After an adequate diagnostic workup and longitudinal followup of the child indicates a negative organic diagnosis, then repeated physicals, workups, laboratory tests, x-rays, consultations, hospitalizations, etc. are contraindicated unless there are new developments.

A holistic physician must coordinate the treatment plan with parents, educators, community leaders, and other physicians or the child is likely to manipulate those involved. The child must be weaned from his parents and desensitized to the outside world. Father's involvement is often essential. Often it is better to deal with him directly rather than through mother. The child will often play out the core problem. Suggestion can sometimes perform dramatic results with such a child especially if he is given an honorable way out of his predicament. Such therapy often offers relatively prompt attainment of limited therapeutic goals which may save the child's life, relieve the family of great pressure, and prepare the family for the attainment of more sophisticated therapeutic objectives later.

These problems are difficult to treat and sometimes it is not just the patient or the mother but the physician who develops anxiety, avoids the problem, changes the subject, or doesn't want to hear. In some patients it is wise and possible to explore the deeper psychopathology described briefly above which may be the basis for the symptoms.

TIME DISORIENTATION IN MILDLY RETARDED CHILDREN WITH SEQUENCING DISORDER: DIAGNOSIS AND TREATMENT

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This is a report of an extension of work presented at the 1967 annual meeting of the American Orthopsychiatric Association ("Remediation for a Mentally Retarded Child with a Language Disorder Associated with Tasks Involving Spatial Orientation and Sequencing: a Case Study," Workshop 40: Psychotherapy in Mental Retardation). In that presentation the authors described the cognitive restructuring techniques used to help a child with a language disorder to orient himself in space and in time. One critical aspect of the procedure was training in sequential organization. The use of the child's body to establish directional anchors, the principles of generalization from his own body to cardboard figures of men, and, finally, the internalization of movement through imagery were described as they applied to learning temporal and numerical sequences.

In the present report the authors describe the application of these techniques to six children grouped not by IQ but by a common disability: temporal disorientation.

They were all emotionally disturbed, warranting placement in a residential setting. IQ's ranged from below 44 to 72; the age range was 10 to 14. Though the children were also disoriented in space, the present paper covers only remedial techniques related to temporal disorientation.

None of the children knew how to tell time; most did not know the days of the week or the months of the year. Even those who knew the days and months did not understand the temporal connotations of "before" and "after." This was exemplified in failures to tell the number before or after a given number, and failures to tell the day or month before or after a given day or month. All had difficulty understanding "the day before yesterday" and "the day after tomorrow."

Two teachers worked with two of the most retarded children, one boy and one girl, at the residential school and with four girls in a separate group. Though the children in each group were in the same room and working toward the same goal, the tasks had to be highly individualized to keep them all moving at approximately the same pace. Twelve stools into each of which a figure of a man was placed were aligned. The children learned that a movement in the direction the men faced constituted a before move, and that a movement backward was to be labeled an after move. They stepped from stool to stool announcing or responding to a request to move before and after. Numbers from 1-12 were placed on each stool; now the task was to stand at given number and decide to move after or before while reciting the following: "I'm at 4, I move before to 3. Before 4 is 3." The arrangement of the stools and men was slowly transformed from a linear to a circular arrangement, so that after 12 was 1. Learning to read a clock followed these exercises. A similar procedure was used with the days of the week and months of the year. Reliance on imagery and memory was fostered by placing the numerals (and printed days and months) on the stools upside down so they could not be read, and ultimately by removing the men-figures from the stools.

All six children eventually learned and used temporal concepts in many experimental and social contexts.

A FOLLOWUP STUDY OF CHILDREN WITH ANOREXIA NERVOSA

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Although there are many clinical reports of children and adults with anorexia nervosa, there are very few reports of followup studies of patients who were treated during childhood.

The present series consists of 30 children with severe anorexia who were treated by staff members of Hawthorn Center initially as inpatients over a 16-year period from 1951 to 1967. The group of children is described in detail, including a breakdown into various subcategories. Treatment methods including intensive

psychotherapy, individualized nursing care, and specific milieu programing are discussed.

The majority of the patients have been reevaluated in the outpatient clinic, with a followup period of one to 17 years. Immediate posthospital adjustment as well as long term adjustment is described. Areas of functioning that are discussed include: eating problems, weight loss or gain, general health, menstrual history, pregnancies, school and work histories, and social adjustment. We have been interested in assessing the relationship of the course of the illness to changes in family dynamics. In addition we have stressed the patient's recapitulation of his illness and treatment as well as his evaluation of his current function.

Finally, we have attempted to evaluate the long-range personality development of children who have had severe anorexia.

BODY IMAGE AND AMPUTATIONS: A PSYCHOLOGICAL INVESTIGATION OF CHILDREN

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The major focus of this investigation is to reach a broader understanding of the overall personality structure of children with major physical distortions of their body. We chose children who had either congenital or traumatic amputations and studied such processes as: (1) depression and mourning, (2) symbolic value of body loss, (3) body image percept, (4) nature of defensive structure, (5) adaptive patterns or compensatory mechanisms of adjustment, and (6) relationship between family dynamics, the amputation, and the child's adjustment.

Thorough medical examinations over a period of time were available from an amputee clinic on approximately 20 children ranging from young childhood through adolescence. Current psychiatric interviews and psychological testing and case histories have been gathered on each of these children, and conclusions are presented in the paper.

AN EXAMINATION OF ERIKSON'S THEORY FROM THE PERSPECTIVE OF A STUDY OF CONGENITALLY PARAPLEGIC CHILDREN

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The study of congenitally paraplegic children provides a unique opportunity to evaluate personality theories which postulate a close correlation between physical and psychosocial growth. Erikson's theory, an elaboration on Freud, postulates eight life stages, each of which must be negotiated with some success for the lifelong process of maturation to proceed well. Since each stage builds on previous ones, serious failure reverberates through later crises. In each stage, physical, psychological, and social factors interrelate toward the development of certain modes of relating to oneself and the world, e.g., the development of a sense of autonomy (stage II) is associated with developing bowel and bladder control and voluntary muscle patterns.

Myelodysplastic children—children born with a spinal defect producing lower-limb paralysis, incontinence, and loss of sensation in anal and genital zones—lack the physical characteristics necessary to negotiate stage II (“elimination organs and musculature”) and stage III (“locomotion and the genitals”). It is expected that these children will not experience the mastery associated with movement through these stages, nor the modal style associated with each stage. Specifically, it is expected they will not develop an adequate sense of “autonomy” (stage II, ages 1–3) nor “initiative” (stage III, ages 3–6). Further, the social modalities associated with these stages should be impaired—“holding on and letting go” (II) and aggressively going after things (III). Since stage III is so intimately built on II, the impairment should be cumulative and therefore greater. On the other hand, development in stage I (birth to age 1), involving the oral zone and sensory organs, should not suffer as a result of physical handicap.

Evidence bearing on this prediction comes from ratings of characteristics of a group of myelodysplastic children and from studies of individual cases. Six clinicians from four different professions rated 60 myelodysplastic children (diagnosis: meningomyelocele) on a nine-point bipolar scale. Ages of the children ranged from 6 months to 15 years. All were followed regularly in the clinic and were typically well-known to the clinicians. One extremity of the bipolar scale defined a child as apathetic, passive, lethargic, listless, dependent, etc., while the other extremity defined him as full of life, curious, responsive to the environment, independent, etc.

Plotting the mean rating of each child against age shows a progressive development of apathy from the 12-18-month age range to ages 3–4 years. This supports the prediction from Eriksonian theory. Descriptive phrases taken from Erikson's writings and applied to these children by their mothers also tend to support the predictions. Case studies show further agreement. An 11-month-old boy was seen as having essentially normal psychological development by his parents and the

clinic personnel; while a 3½-year-old girl was content to sit passively with her usual playthings, showing little interest or excitement in new playthings or objects; and a 10-year-old extremely apathetic girl was retrospectively seen to have developed this pattern at 3 and 4 years of age.

Erikson describes the conflicts associated with each stage as struggles between psychic force and counterforce which lead either to resolution or to stalemate, regression or neurotic compromise. In these children, the absence of the physical events produces a different situation—the crisis and conflict never appear. Hence, these children do not suffer from *unresolved* developmental crisis with residual regressions and neuroses. They seem never to have become involved in these struggles.

The value of Erikson's theory as applied to a different population can be seen from this study. The need for more precise definition and systematic rigor is also clear. Rapaport's earlier statement citing this need still remains.

DIFFERENTIAL ASSESSMENT OF "BLINDISMS"

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As a basis for the consideration of the diverse origins and the possible meanings of so-called "blindisms," we have chosen illustrative materials from the case histories of three congenitally blind infants who have been followed from some time in their first year of life through the succeeding one to two years, depending on the present age of the child.

For the past three years the Child Development Project at the University of Michigan has been engaged in a longitudinal study of infants blind from birth. This project, designed by and under the direction of Selma Fraiberg, is a continuation and extension of Mrs. Fraiberg's work with blind children begun in 1960.

The babies selected for the study are totally blind from birth or have minimal light perception. As far as can be ascertained through complete medical examination, the babies have no other sensory deficits and no sign of central nervous system damage. The babies are followed through twice monthly visits to the home during which film records are obtained and continuous observational notes of the babies' behavior are taken by a trained observer. In addition, guidance is offered to the parents concerning the special problems of the blind infant and assistance is given in the form of educational techniques and approaches that will facilitate the child's development.

For the purposes of this presentation, we will limit our discussion to a consideration of specific gestures or mannerisms occurring in the life histories of the three children that seem to us to have certain similarities to those described as "blindisms" in the general literature. In common usage, this term covers a wide variety of activities ranging from minor head and hand movements (head turning, hand

twisting) through various rhythmic body activities (rocking, swaying, etc.) to highly complex ritualistic patterns of behavior that are reminiscent of severely disturbed (autistic or schizophrenic) children or adults.

While many of these behaviors may also be found in sighted children, they seem to occur with greater frequency and to last longer in the blind child. In our current sample of 10 babies such behaviors range from one child who has shown none at all during his first two years to one child who in his second year became markedly engrossed in a series of repetitive, stereotyped activity that persisted for a considerable period of time. Between these two extremes, we find instances of mannerisms similar to certain "blindisms" that are characteristic of the individual child at particular times and under particular circumstances, often serving adaptive functions to the child at the time. In these instances, the behavior is usually transitory and yields to further developmental progress or to educational intervention. Our first two examples are taken from the histories of children in this middle range; the third from the history of the child whose involvement in repetitive activity was the most extreme in our sample.

Since the sample includes only children who have no other deficits apart from the blindness, we can make no generalizations for populations of children where other deficits may be present nor can we make predictions about the occurrence of such behavior patterns in the children when they are older. What we hope to do is engender further discussion of the problems and complexities of these behaviors and to share our current thinking about the relevance or possible functional significance for the development of blind children.

MINIMAL BRAIN DYSFUNCTION: THE ROLE OF DEPRESSION

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This paper is concerned with the dichotomous conceptualization of the hyperkinetic syndrome by the mental health professions. An attempt is made to view the syndrome as the result of possible combinations of both constitutional-organic and psychologic-environmental factors. The importance of such etiologic factors in individual children, as well as the way in which they intermingle and overlap, are discussed, using cases or excerpts from cases as illustrations.

A sharper focus is placed upon the possible relationship between hyperkinetic syndrome in children, with or without minimal brain dysfunction, and the existence of depression. The necessity of considering physical and psychogenetic factors in these children's development is noted. A discussion of the dynamic factors leading to some explanation of the depressive elements in these children is included.

A COMMUNITY PROGRAM TO TREAT CHILDREN WITH MINIMAL BRAIN DYSFUNCTION, INCLUDING A SPECIAL SCHOOL PROGRAM

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This paper deals with the use of the concept of minimal brain dysfunction in a child guidance clinic setting. In the past four years a program has evolved which stresses case finding of such children, their evaluation, diagnosis, and treatment. It is becoming increasingly apparent that numerically this constitutes a sizeable segment of child population and that these children constitute a higher risk of emotional illness and learning disabilities. Of equal importance, the emphasis upon this type of child has served as an interface between the child guidance clinic, schools, and other child agencies.

The concept of minimal brain dysfunction stresses that the neurological organization of the child determines temperament of the child as well as learning abilities, which in turn may give rise to secondary symptoms when the child fails to achieve or enters into adverse relationships with others. Treatment consists of modifying favorably the child's neurological organization by use of medication, of providing special types of education or training, and of attempting to modify environmental stresses.

Medication used in these children have been of three types: stimulants, tranquilizers, and anticonvulsants. We have attempted to improve target symptoms such as hyperactive behavior, attention, perception. This results in the child being easier to live with, improved learning, and better performance in some tasks such as writing, gross motor activities, or speech.

Mothers' groups conducted by the clinic staff provide the mothers increased understanding, specific help in child-rearing problems, a lessening of guilt related to their child, and specific ways of helping their child educationally. Mothers become more active in school affairs thus acting as catalysts for school-based programs designed for disadvantaged children.

A Montessori classroom was added to the clinic program to enable the clinic staff to become familiar with classroom behavior of the children as well as with specific techniques of educating these children. As these children improved, school administrators became more interested in evaluation and consultation through the clinic staff and our workers more able to use their psychological and psychiatric training and experience as it relates to the child in the classroom. As a definitive program evolved it became easy to extend our services into the outlying areas served by the clinic using traditional caretakers in these areas as our main contacts.

With this program we are now working directly with all the school social workers of our 10-county area. They screen all elementary age children referred and provide a social history on all children we evaluate. We provide psychological testing, a psychiatric and neurological examination. This is followed by a conference with the school social worker who is the direct contact with the school and the parent. With a staff of six professional persons (two psychiatrists, two clinical

psychologists, two psychiatric social workers) we are able to effectively evaluate, plan for, and/or treat 1,000 new children a year. With a child population of approximately 35,000, we are able to reach one child in 10 each three years.

COMMUNICATION, VERBAL AND NONVERBAL, WITH EMOTIONALLY DISTURBED CHILDREN

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Based on the premise that those forms of language which are the very simplest carry a token of universality, this paper attempts to assist therapists in their search for clues to children's meanings in their words and play.

Meanings are masked in play, in a process apparently like that of the masking in dreams, making play an especially convenient medium for the child whose curiosity and oral expression have become blocked. Also, English has many words of double meaning or mixed associations, making communication particularly difficult for children whose ability to concentrate on meaning is reduced due to emotional and/or organic factors.

Material from a 1956 study of the histories and responses of latency children who were nonverbal in therapy is here expanded to include verbal patterns. Words found confusing to children because of unfamiliarity, double meaning, or overcathexis, and confusing symbols and word patterns are listed. The author defines these in terms of what meanings they have had for children whose therapy she has conducted or supervised over 20 years.

The paper includes observations on children's patterns of omitting or hiding symbols, omitting letters and connectives, making substitutions. Sequence and economy in the use of symbols, uses of body language and of silence are discussed.

Word and symbol lists are in alphabetical order, for potential use in a handbook for therapists.

AN APPROACH TO THE TREATMENT OF DISADVANTAGED, PRE-SCHOOL, PREVERBAL PSYCHOTIC CHILDREN AND THEIR PARENTS IN AN OUTPATIENT CLINIC

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This paper reports part of a project exploring the relationship between the communication problems of preschool, preverbal psychotic boys and the communication problems between their two parents. It will describe the treatment program

which utilizes all the persons most directly involved with the children and then will focus only on the first-year treatment changes in the two parents. The paper aims to define (1) the stages in the parents' growth towards communication in their group therapy sessions and (2) the conditions that seemed to be related to this growth in three sets of parent couples.

The goal of the group therapy sessions with the parents was to help each parent communicate with his spouse in more explicit and defined ways. This goal had little to do directly with the fact that these were parents of preschool, preverbal psychotic boys but rather that these were unhappy people unable to communicate with each other. Communication is regarded here as a transaction between two persons who experience each other as separately defined. These parents were unable to communicate with each other because they did not experience each other as separately bounded persons. The strategy in the treatment, then, was directed towards providing conditions that would stimulate the parent to experience himself as separate from his spouse and as separate from his child. This goal was implemented through a group therapy approach in which the therapist was active and provided the group with concrete experiences such as going swimming together.

Data: The parents' weekly group therapy sessions were taped, and every three months the following drawings were collected: (1) Draw a Person, (2) Draw a Mother (or Father), (3) Draw You and Your Spouse. The taped recordings were analyzed for statements that gave evidence of growth towards separation and growth towards communication. The drawings were scored for (1) definition of form, (2) sexual differentiation, and (3) communication.

Findings: All the parents in this severely deprived minority group benefited from the group therapy sessions. The focus of the group discussions shifted each three-month period. In the first three months, the parents focussed on their disturbed child and their affective reaction to that child's thrust towards independence. In the second three months, the parents confronted each other with what the other was doing wrong that made the child disturbed. In the third three months, each parent reported engaging in new activities that took him away from the child and from his spouse, activities like trips which gave the parent a sense of achievement and a sense of pleasure. By the end of the first year, the parents were able to confront each other and other members of the group with the other's behavior in the group. The two parents began to be supportive and positive towards each other.

The parent-couples who showed the most dramatic growth towards communication with each other, as this growth was reflected in their drawings, were those parents who not only reacted to their child's thrust towards independence with painful affect but also could utilize this affective experience for their own growth. The stimulation for growth in the father who made the most change came from his son's constant impinging on the father and forcing the father to experience and define himself.

VARIATION IN TREATMENT TECHNIQUE IN GROUP ACTIVITY THERAPY FOR CHILDREN

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Some of Ginnott's notions of group psychotherapy with children have been utilized in the group activity therapy program at the Irving Schwartz Institute. Experience with them is described, as well as innovations in technique superimposed upon Ginnott's approach.

In brief, the children are selected for two different types of activity therapy; one for children with neurotic-type difficulties and the other for children who have ego impairment, the latter implying but not requiring the diagnosis of organic brain damage. Equipment available for the neurotic group is minimal while for the ego-impaired group, woodshop, structured activities, and games are provided. The session for the neurotic group is kept quite fluid, with the goal being maximal elicitation of fantasies and expression of feelings about relevant others. Limit-setting is maintained only for the preservation of personal property and to prevent extreme physical assault. For the ego-impaired group, the session is divided into two distinct sections. The first is limited to structured group discussion about current activities and daily events; the second offers either a structured physical activity or use of woodshop in which a project must be planned and carried out. At all times, the potential for frustration and failure is reduced to a minimum and disorganization is not tolerated.

The essential difference in technique used with the two groups is the way in which anxiety is utilized. With the neurotic group, it is allowed to develop, if anything encouraged, by the nature of the material and the way the therapists interact with the children. The selection of the group members further provides certain irritability of defensive operations between the boys which encourages the development of tension. The way in which they are helped to cope with such tensions constitutes the therapeutic work. But in the ego-impaired group, the anxiety tension is reduced to a minimum, the children are guided in learning how to cope in situations of minimal tension. As they become more adept at this, they are increasingly allowed to experience the vicissitudes of a less structured situation, but one which does not extend past their frustration tolerance causing disintegration in defensive operations.

The productions of these two groups are quite different. In the neurotic group primary process material is produced, at times reaching the threat of being translated into physical and assaultive behavior against the therapist and occasionally against each other even by children who were originally inhibited. In the ego-impaired group such fantasies do not occur, but if presented are actively discouraged.

Changes in behavior outside the therapy group is quite rapid in the ego-impaired children, as reflected in school reports often after only two months. Their behavior in the group seems directly related to behavior in school. In the neurotic group,

one would imagine these children whose productions are quite unmanageable to be equally so in school. This has not been the case, and in the school setting they too have shown great improvement in behavior.

Finally, this paper presents discussions of the countertransference effects of these various techniques upon the therapist.

A THERAPEUTIC CLUB FOR SEVERELY DISTURBED PREPUBERTAL BOYS

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Due to the shortage of residential treatment centers and day treatment facilities for severely disturbed children, clinics dealing with such children must either ignore them or devise methods of working with them in the community. The problem is particularly acute in those clinics located in urban slums, where such disorders are endemic. At a child guidance clinic in the East Harlem section of New York City we have been working since 1960 with NIMH support to devise a treatment program for children with severe ego disorders. On the assumption that the crucial element in residential and day treatment is the amount of time spent in the therapeutic setting ("major time care"), we established a therapeutic club, which meets daily after school, as the core of our program. In a previous paper, we reported the successful use of this method with latency-age children. This paper describes the use of a therapeutic club in the treatment of a group of prepubertal boys.

When the club began, five 10-year-old boys were selected from those for whom residential or day treatment had been recommended after a clinical evaluation. In the course of the first year others were added to bring the group up to a total of eight children. All had been referred from their schools because of uncontrollable or peculiar behavior and most were on the verge of suspension. Diagnostically, the range was from severe character disorder to psychosis.

The boys were assigned to a club which met for two hours daily after school for three years in a community center associated with the clinic. During the summers the group was loosely attached to a day camp in the community center. Two male group leaders were present at all times. One of these was a teacher by profession and the other was an untrained group worker indigenous to the community. Both were necessary to protect the boys from their regressive, destructive potential and to provide differential gratifications for a group which, though homogeneous in age, was by no means homogeneous in development. Specific activities developed out of the needs and interests of the group and the talents of the group leaders.

In this context, the group leaders attempted to reinforce controls, improve reality testing, and through discussion and interaction tried to assist the boys in their ego development. Individual therapy was provided for four of the boys. Family casework and school consultation was provided for all. The entire staff met

twice weekly to coordinate these efforts, deal with specific crises, evaluate progress, and plan future activities. Evaluation was clinical and social. A battery of psychological tests was administered yearly.

Eight boys were involved in the club for periods of two to three years. They were maintained in the community, in their own homes, and in the public school system. Though none can be considered "cured," all have improved. The range of improvement was from slight to remarkable and was achieved despite the developmental pressures of prepuberty and environmental stress. (Three of the boys' fathers died during the treatment period.) Clinically we saw strengthening of impulse control, reality testing, and self-esteem. Periods of severe regression diminished and object relations improved. These changes were reflected in reports from homes and schools and were verified on psychological testing by a trend toward better organization, integration, and differentiation.

Though there were many features of the treatment program that are standard child guidance procedures, we want to stress the significance of the therapeutic club. It is striking to see the importance the club takes on in the lives of these children. Altogether, 22 children have been involved in our therapeutic clubs to date. Only two have withdrawn from treatment of their own accord. The factors involved in this will be discussed in terms of opportunities for real gratification, emotional catharsis and, most importantly, the chance to develop corrective object relationships. We will also discuss the difference between this club and our previous therapeutic club for latency-age children. In brief, the younger children are easier to work with and show a greater degree of improvement, yet the club was of benefit for both groups.

We have found the therapeutic club to be of value in treating hitherto "untreatable" children in our clinic. We believe it is a technique which can be adapted to many settings.

PREADOLESCENT GIRLS IN "TRANSITIONAL" GROUP THERAPY

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Group therapy with children and adolescents has been conducted at the University of Utah Medical Center for several years. These are open-ended, ongoing groups which meet weekly throughout the year (summers included). The therapists have used the more traditional nondirective methods in the activity groups, or used an adolescent discussion group model.

Early in our experience it became obvious to us that our latency group sessions were not meeting the needs of some of the girls who were moving into adolescence

but were not yet ready for termination and were not yet ready to accept more physically quiescent and anxiety-producing discussion groups. We wished to offer them a new experience which, hopefully, would promote psychosocial and psychosexual growth as they attempted to bridge the gap between latency and adolescence. Changes were made in the physical setting. A room was used to promote more "talk" and less physical activity, and yet allow for some regression to old activities when they became too anxious. As we continued to meet with these girls, we observed that other changes became necessary in, for example, the ground rules, use of food, and kinds of activities more appropriately designed to allow expression of feelings.

After the weekly girls' group meeting, the therapist recorded in detail a description of the individual girl's behavior, group interaction, and the therapist's feelings, attitudes, and behavior with group. These were reviewed and discussed with other staff members.

Some of the conclusions that were reached:

1. Without the availability of an activity-oriented room, the therapist had to find suitable new modes to assist the girls in expressing their thoughts and feelings in the group.

2. Regressive, dependent behavior was more difficult to express openly and thus less available for therapeutic intervention.

3. The girls' changing attitudes toward authority, attendant to psychosocial and psychosexual maturation, demanded changes in the therapist's role which created further ambivalence in the girls' relationship with the therapist.

4. Group behaviors were identified which could be considered deterrents to growth or else which promoted psychological development.

It was concluded that there are many factors influencing and modifying the behavior in these preadolescent girls. An understanding of these changes and careful planning in the group helps to promote growth and lessen the girls' and therapist's negative influences in their interactions.

A TOKEN ECONOMY IN A RESIDENTIAL TREATMENT SETTING FOR EMOTIONALLY DISTURBED CHILDREN

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In dealing with acting-out children in residential care two of the major problems are (1) to so structure the milieu that the manipulation is minimized and (2) to prevent the development of a punitive system of controlling acting-out children. A token economy in combination with a carefully structured program and explicit crisis intervention system offers great potential for dealing with these two basic

problems. The staff has much of its uncertainty removed and the token system, if properly constructed, requires the staff to focus on "good" instead of simply "bad" behavior. An additional benefit of a good token system is that it can provide a dependent variable measure of both the program itself and a particular child's progress within it.

The program to be described has three components: (1) general program content (school, recreation, and in-unit activities), (2) crisis intervention procedures (a hierarchy of intervention), (3) the token system. The token system permeates the entire program and is divided into three broad categories: (1) obligatory token earning activities (daily routines, housekeeping, and school), (2) optional token earning times where the awarding of tokens is left to the discretion of child-care staff, and (3) token spending times.

There are four levels to the system. Level 1 is a subsistence level which serves mostly as a means of orientation to the unit and its staff and a backup or contrast for the other levels. Levels 2 through 4 increase the number of tokens which can be earned and their "purchasing power," culminating at Level 4 in a monetary allowance and off-ground passes. All privileges, phone calls, home visits, TV, and recreational activities (except minimal ones) must be earned. The goal of the program is not to give the children a good time but to teach them that the payoff in this Anglo-Saxon Puritanical world comes from work (i.e., school) and what is euphemistically called "good citizenship."

Experience with eight emotionally disturbed children consisting of six boys and two girls with diagnoses unsocialized aggressive reaction (6) and withdrawing reaction (2) has revealed the following.

1. A token system at a therapeutic level is best understood within a behavior modification paradigm, but at the level of implementation, in general systems theory. The token system is a system of some internal complexity so that changes in one portion result in distortions of other parts, notably the "purchasing power" of the tokens. The token system also has large interfaces with other systems, notably the larger institution and the external milieu.

2. Resistance to the token system from clinicians trained in traditional modes is often atheoretical and stems from (a) clinical judgment on wisdom, efficacy, and ethics of procedures and (b) conflicting value systems relating to the necessity of studying phenomena versus action.

3. Punishment (crisis intervention) procedures cause most difficulty. The response of children tends to have a diminishing periodicity with high density of punishment alternating with relatively free periods. The exact periodicity varies from child to child, in some several weeks, in others at most a few days.

4. Maintaining the effectiveness of the tokens requires considerable ingenuity in ringing the changes in the backups for which tokens can be exchanged.

5. The need for staff training is no less than with other therapeutic programs, though the explicitness of the structure makes deviations more apparent and in some ways thus more amenable to on-the-job training.

6. A milieu therapy program of this kind reveals that in the 6-12 age range

there must be two subprograms, one for the 6-9 group and the other for the 10-12 group.

7. The program as a whole readily controls crises and major deviant behaviors. Children can be maintained in special classes but few children show signs of substantial character change, certainly not within a nine months period.

8. Child-care staff can be trained to collect a significant amount of research data without interference with their caring functions.

USES AND APPLICATIONS OF THE METAPSYCHOLOGICAL PROFILE IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN

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The uses and applications of the metapsychological profile in a residential treatment center for children are explored within the framework of five questions:

1. What light can the profile shed on the diagnosis and personality characteristics of a child admitted for treatment?
2. What elements in the profile might be most useful in selecting children for admission and predicting outcome?
3. What elements in, or modifications of, the profile might be selected for monitoring progress during treatment?
4. What criteria in the profile need to be met for the various discharge plans available?
5. How may the profile serve to sharpen and improve various aspects of the treatment program?

An initial metapsychological profile was drawn on each child within 90 days of admission. Subsequent profiles, or part profiles, were drawn as the need arose; and a second metapsychological profile was drawn after 12 months or just prior to discharge, whichever was the sooner. Each profile was discussed fully at a total staff meeting. Three profiles were presented in April 1968 to Dr. Anna Freud to ensure that our understanding of the profile was correct.

The metapsychological profile appears to provide a systematic account of the strengths and weaknesses of the individual child. The process of drawing a profile encourages the staff to view the child as the complex and developing individual he is, and counteracts the tendency to focus attention on a single aspect. The various skills of the staff were also sharpened by practice in this process. The process was especially useful in defining the diagnosis and characteristics of the child. The efficiency of the process of establishing a profile was markedly enhanced with practice,

to the point where a detailed orderly picture of the child could be obtained with deftness and little extra effort. Through the use of the profile, shifts in emphasis, elaboration, and changes in treatment modalities could be made earlier and more rationally than before the profile was used as a monitoring device. Also, more accurate predictions of outcome could be made through the process of using the profile. Further, the process of developing each profile proved useful in arranging discharge plans.

CULTURAL DEPRIVATION: OPERATIONAL DEFINITION IN TERMS OF LANGUAGE DEVELOPMENT

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Educators and child care workers concerned with the phenomenon of cultural deprivation are faced with the problem of a lack of rigorous and common conceptualization of terms. Also, there has been a failure to operationally define and measure the effects of variation in environmental stimuli on the development of specific behaviors in children. Two divergent views, one emphasizing inadequacies in cultural and social experiences, the other focusing on deficiencies in the development of cognitive skills, have strongly influenced the planning of remedial programs for deprived children. The present study illustrates the need for integration of both approaches in research and provision of services for deprived children.

A variety of common vegetables in their natural form were presented individually to kindergarten children from a public school in an urban poverty area and to children from a private, middle-class school. The children were asked to identify the vegetables in terms of having ever seen or eaten them and by naming them. Our essential findings can be summarized as follows: In comparison with children from an urban poverty area, private kindergarten children had been exposed to a wider variety of vegetables. The experience of both groups in terms of number of different vegetables eaten was substantially the same. When the number of vegetables seen or eaten was held constant for the two groups, the poverty school children were less able to name the vegetables with which they had had experience. Finally, the efficiency of naming ability appeared to be developing at a much faster rate among the private school children.

The results clearly illustrated differential development of language ability between the two preschool age groups. Furthermore, our use of vegetables as test objects was done purposely to suggest that the subject matters of food and eating may be very useful areas for teaching, both in the home and in school programs. Most research in nutrition is highly clinical, and there is a gap in our scientific knowledge of the cultural aspects of eating, especially among children.

SCHOOL MENTAL HEALTH

APPROACHES TO ETIOLOGY AND REMEDIATION OF MAJOR LEARNING PROBLEMS IN CHILDREN

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Learning problems are commonly regarded as the most frequent referral complaint of childhood and adolescence. While it is recognized that these disabilities in learning occur for a wide variety of reasons, most controversy appears to arise over diagnosis in instances where mental retardation, demonstrable neurological involvement, major psychopathology such as psychosis or delinquency, transient reaction to stress, or inadequate educational opportunities can be readily ruled out. The resultant group of intellectually able children whose longstanding difficulty in school learning is frequently their only disability has been viewed from two distinctive positions.

Proponents of neurogenic etiology (Bender; Gallagher) are convinced that these children suffer from minimal neurological defects or developmental lags. Adherents of psychogenic etiology (Sperry) contend that the learning problem is the focal symptom of a neurotic conflict. The former position has been identified for the most part with neurologists, pediatricians, neuropsychiatrists, and educators, and the latter with the psychoanalytically oriented clinician. In many instances it appears that a neurogenic or psychogenic diagnosis is arrived at on the basis of the same objective criteria interpreted from within an alternate theoretical framework.

Prior etiological commitment not only selectively influences the establishment of the diagnosis but more importantly often heavily shapes the subsequently recommended remedial measures. For example, adherents of the neurological or developmental position frequently urge the implementation of remedial tutoring (Fernald; Gillingham and Stillman). The assumption is made that individual instruction in undeveloped achievement skills by a knowledgeable and sympathetic teacher can overcome the skill deficiency. This approach is advanced as well by those who feel that the disability is due to faulty teaching methods often in interaction with a neurological or developmental vulnerability.

A related, more indirect method, is that of cognitive ability training (Kephart), which has grown out of studies with neurologically impaired children. This approach contends that tutoring often proves ineffective because it ignores the necessary development of the cognitive antecedents on which the basic skill is grounded. Thus, it is argued that training through directed exercises in directionally or form perception, for example, may prove prerequisite to successful response to remedial tutoring in spelling.

Adherents of the psychogenic position (Blanchard; Pearson) have traditionally indicated that individual psychotherapy or analysis is the method of choice in children with psychogenic learning inhibitions. From this perspective the learning inhibition is a symptom of unconscious neurotic conflict. As such, it is believed that the disability will prove relatively impervious to remedial tutoring, and will abate only when the core conflict has been resolved.

A more recent approach stemming from the application of academic learning theory to clinical phenomena (Rachman) also perceives the learning disability as maladaptive learned behavior but takes an opposite approach to its resolution. It is asserted that the learning symptom can be frontally attacked since it is not viewed as linked to any underlying motivational structure. Indeed, since the learning difficulty is independent of any instinctual conflict, the traditional expectation of symptom substitution through successful direct behavioral modification of the disability is felt to be unfounded. While behavior therapy has been applied to a variety of childhood syndromes, including phobias, delinquency, and autism, its use with children with learning problems has been largely restricted with few exceptions (Rachman and Lowenstein) to mental retardates.

Another approach, therapeutic tutoring (Prentice and Sperry) strikes a middle position between focusing largely on the learning disability itself or on the presumptive underlying neurotic conflict. Therapeutic tutoring refers to psychoanalytically based remedial efforts directed toward the child's school inhibitions. While both the therapeutic and educational functions are retained, the emphasis on the latter predominates. Educational methods and interventions are strategically related to unconscious fantasies sustaining the learning inhibition. Complex motivational dynamics are viewed as etiologic in the learning disability and as motivating the immediate resistance often encountered in tutorial approaches.

In sum, a variety of individual remedial approaches to major learning problems in children have been advanced. Empirical support for the superiority of any single approach generally or of specific approaches to certain types of cases is absent. As a consequence, the clinician must ensure that his own theoretical biases do not preclude his consideration of the full range of remedial interventions no matter what the assumed etiology in any specific case.

STRUCTURED FAMILY-ORIENTED THERAPY FOR SCHOOL BEHAVIOR AND LEARNING DISORDERS

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A range of therapeutic interventions in which treatment is structured around the school problem and its family component is presented. Approaches discussed include: (1) individual or parent counseling in which family attitudes, values, and feelings about the learning process and school behavior norms, as well as inter-

familial problems negatively affecting school adjustment, are actively brought into the content of treatment by the therapist; (2) concurrent individual and parent counseling; (3) individual psychoeducational therapy in which parents are brought in for parent-child tutoring sessions; and (4) conjoint family therapy as the treatment modality. Case material is used to illustrate each approach.

Extensive experience at our center in treating children and adolescents with school-related problems has confirmed the value of structuring therapy to deal with the school problem itself. Although the family's stake in maintaining the difficulty is frequently a crucial etiological factor, we have observed that parents are less threatened by and more willing to participate in family group, conjoint, or parent-child sessions when treatment is focused directly on the school problem. We have noticed that active participation of parents in the treatment program often results in improved home-school relationships. On the other side of the coin, we have seen that when the same-sex parent does not become involved in or support the therapy, treatment failure frequently results. In working with adolescents, we have found that they derive much benefit from a shared-responsibility orientation in which the explicit goal is a more satisfying school milieu experience.

In our work, we have encountered a number of unexpected treatment failures that we eventually grouped together in a single category in which the child's learning difficulty was due to identification with a primary learning defect in the parent. Since the school problem was being unwittingly perpetuated by each parent contact, a method had to be devised for simultaneous modification of the defect in parent and child. The technique consisted of bringing the parent into the therapy session as an observer of or participant in a tutoring session. The intensity of the experience in identifying and/or interacting with both child and the therapist often rekindles the parent's own conflicted school experience, allowing parent change which is then reflected in the child. Other advantages of this innovative technique: (1) A more immediate and heightened involvement of parent and child in the therapeutic effort. (2) A "face-validity," commonsense appeal, and a transactional impact that is difficult for the parent to depreciate or ignore. (3) By focusing directly on a critical aspect of ego functioning, any appreciable change in the parental model produces significant improvement in the child. (4) The process of structured parent-child interaction, once initiated, can be carried on between therapy sessions as "homework." The parent-tutor technique has been successful in altering parent model with consequent improvement in the child's school performance.

School behavior disorders have been found to respond to these focused approaches as readily as have learning difficulties. It is a reasonably accurate generalization that school behavior and learning disorders are found side-by-side when we look carefully enough at a particular child's maladaptive performance. Role-playing in reenacting school "discipline" problem situations can be useful for child and family.

Review of case data and followup study indicates that treatment effectiveness often extends beyond the school milieu to other important facets of the child's or adolescent's life. In addition, we have concluded that choice of modality is a key factor in prognosis of therapy.

LEARNING DISABILITIES: WHAT ARE WE ASSESSING?

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The research reported in this paper focused on an analysis of the performance characteristics of first grade children. Five dependent variables were arbitrarily identified and used as the basis for labeling low performers. These variables were: (1) Stanford-Binet, L-M, IQ, (2) Memory-for-Design, Detroit Tests of Learning Aptitude, (3) Total Score, Developmental Test of Visual Perception, (4) Total Language Score, Illinois Test of Psycholinguistic Abilities, and (5) Total Score, Metropolitan Readiness Test.

For each dependent variable, the bottom 20% from a population of 209 disadvantaged children were identified. Profiles on all measures, exclusive of the dependent variable, were plotted for low performers, which was contrasted with the population mean. This process of continuous redesignation of the dependent variable produced five samples of low performers.

One-way analyses of variance were computed separately for the low performers on each dependent variable for all independent variables. If the dependent variable was the unique source of the difference in performance between the population and the low performers on a variety of other measures, one-way analysis of variance would be expected to yield nonsignificant differences among the mean scores. Therefore, the nonspecificity of categories of learning disability was challenged. The arbitrary labeling of children as "language deficit," "visual-perceptual deficit," and so forth without an ability to attribute specific traits to specific groupings suggests an examination of the rationale underlying the definition of the term "specific learning disability."

Implications for the teacher and clinician are considered in the discussion of the results.

DYSLEXIA UNMASKED: A MULTIDISCIPLINARY STUDY OF THE CAUSES OF READING FAILURE

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This study attempts to demonstrate the multiple causes behind the symptom of reading retardation and to determine the relative frequency of these etiologies. Data were collected as part of a program of community psychiatry to train teachers to recognize and to treat children with reading disability. In this program each child and his family were studied psychiatrically, neurologically, psychologically, educationally, and, where indicated, with additional special studies of his peripheral sensory apparatus. With this assessment as a basis, a program of instruction was

built and the child's teacher was supervised in the implementation of this program over the period of a year in a continuing program of consultation and demonstration.

The population described consists of 50 first and second graders attending schools in the lower east side of Manhattan and referred by their teachers because of their difficulty with beginning reading. These children came from 14 different schools in the district, were referred by 34 different teachers, and represent the most severe learning problems in each class. Each was considered by his referring teacher as suffering from "dyslexia."

Results indicate that 37% had signs consistent with a diagnosis of specific (developmental) reading disability. These children demonstrated language skills more than one year below expectancy, had perceptual problems referable to defects in spatial and temporal organization in more than one modality and did not have evidence of structural defect of the central nervous system or of peripheral sensory apparatus.

Another 37% had, in addition to their perceptual defects, abnormality in one or more areas of the neurological examination, in muscle tone and synergy, in cranial nerves, in deep and superficial reflexes, or in gross sensory examination. These children are designated as "organic" in contrast to the group diagnosed as "specific" reading disabilities. Of the children with neurological signs, 15% had IQs below 75 on individual examinations, so that they had not yet reached the level of cognitive development desirable for beginning work in reading.

There was a small group of children (13%) whose slowness in maturation was not specific to language tasks alone, but manifested itself in all areas of functioning. Examination of them elicited generally slow patterns of physical, cognitive, and emotional development. The cause of this could not be ascertained, although it was noted that prematurity was reported in 40% of their birth histories. Schizophrenia was the major diagnosis in 8% of the total group, and one additional child was found to have a hearing loss severe enough to account for his educational retardation.

The presenting problems of dyslexia—failure to make appropriate progress in learning to read—masks a variety of etiologies. Diagnosis in our sample of severely retarded readers showed slightly more than one-third to be specific language disabilities, while the remainder of the group underlined the frequency of neurological defects, schizophrenia, sensory handicap, and generalized immaturity in all areas of functioning.

DYSLEXIA IN FOUR SIBLINGS

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The inability to read, with its long historical background, has been attributed to a variety of factors and identified by a multiplicity of diagnostic terms. For almost

a century investigators have grappled with terms, etiological factors, and remediation. Major emphasis has been placed on intelligence, personality, readiness, motivation, educational techniques, and sensory handicaps.

Recently the terms dyslexia, minimal cerebral dysfunctioning, specific learning disability have become prominent. These diagnostic labels, often used interchangeably, are characterized by heterogeneity of traits both primary and associated, transience of minor neurological signs, and personality problems. Current thinking also stresses the perceptual development which may underlie the development of reading skills and a genetic factor in some forms of dyslexia. Dyslexia, as used here, refers to a specific language disability or the inability to read. Specific language disability includes communication through speaking, writing, and reading, as well as the formulation of ideas in writing or in speech.

There is some evidence, but not conclusive, to support the Swedish study (Hallgren) that "specific dyslexia follows a monohybrid autosomal dominant role of inheritance, that is, a single gene is involved in a dominant, nonsex-linked form of inheritance."

The A family of four children, ranging in age from 10 to 19, suggests the predisposition of a genetic factor in reading disability. All four children, three boys and one girl, evidence a specific language disability despite normal intelligence and good school background.

Both parents are professionals. The four children are disabled readers but the degree of disability ranges from two to five years below grade level.

Psychological data which include an analysis of intellectual functioning, academic achievement, perceptual development, and emotional status show similar and dissimilar traits among the four. Three of the children were diagnosed as dyslexic, the fourth and youngest as dysgraphic with the major problem in spelling.

The presentation of the diagnostic problems and the characteristics of these siblings also takes into account the overall effects of learning disability on family relationships and family attitudes. One of the disruptive factors was the father's lack of understanding of the problem, rigidity, and insistence on high standards and mother's consequent overprotection of her children. The difference in thinking not only led to severe conflict between mother and father but also between father and children. The mother became the buffer who tended to side against father.

Not only was the family life affected by the children's disabilities but so was the children's relationships to their peers. None of the children was able to form close contacts on the outside, each tended to live to and for himself. The family as a unit was also isolated, mother and children particularly.

Plans of treatment which included psychological and educational therapy for the three younger children were established. Psychological treatment took into consideration their communication difficulties, poor identification with others, and resistance to facing their problems. Therapeutic intervention helped to broaden their interests and move them toward peer activities.

The current status of the four (age 13 to 22) reveals that the oldest is a college dropout, the next two are attending a four-year and a two-year college, respectively, and the youngest and least impaired is doing well in junior high school.

DIFFERENTIAL DIAGNOSIS OF CHILDREN WITH PERCEPTUAL-MOTOR DYSFUNCTION AND LEARNING DISABILITIES

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Children who do not learn in school may be classified in a variety of ways: emotionally disturbed or culturally deprived; mentally retarded; socially maladjusted; neurologically handicapped; educationally handicapped; children with minimal brain damage, with perceptual-motor dysfunction, or with learning disabilities. How the problem is defined, by whom, and according to which theoretical orientation determines the treatment prescribed, how and by whom it will be administered.

Based on child development theory and writers such as Gesell and Piaget, this study focused on perceptual-motor development in children because so much of school learning activities depend on and assume intact and well-developed perceptual systems in the child. Contributions to the development of theories of perceptual development have come from the fields of neurology, optometry, psychology, special education, learning theory, and child development. Selected diagnostic and treatment approaches which precede this study were surveyed.

A rationale was developed for the construction of a screening device or instrument for the identification of children with perceptual-motor dysfunction which met the following criteria: ability to sample a broad range of perceptual areas (visual, auditory, tactual, integrative skills, etc.), brevity, economy in administration, and implications for remedial procedures which could be implemented in an urban public school setting. The child's present status, as described by his observed performance, was the center of concern, rather than the etiological bases of his functioning.

The questions to be answered by the study were:

1. Can a test battery or survey be developed which can identify children with perceptual-motor dysfunction?
2. What is the rate of incidence of perceptual-motor dysfunction among normal, educable retardates and emotionally disturbed and socially maladjusted children?
3. What are the curricular and programmatic implications of the findings?
4. Can an adapted form of this battery or survey be developed which can be used by a classroom teacher for identifying children with perceptual-motor dysfunction?

The study included 175 children, a stratified random sample, in Pittsburgh Public Elementary Schools, matched on age, sex, and IQ, drawn from regular classes, from special classes for educable mentally retarded children, and from the adjustment classes for emotionally disturbed and socially maladjusted children. Two instruments were developed, refined, and validated: the Rosner Perceptual Survey which can be administered by an optometrist; and the Rosner-Richman Perceptual Survey which can be given by a teacher or a paraprofessional in about 15 minutes.

Both instruments can be used with considerable confidence to identify children

with perceptual-motor dysfunction. Interinstrument and interrater reliability was established, as well as a measure of external validity.

Incidence rates were found as follows:

Regular classes	13 to 30%
Adjustment classes	68 to 70%
Educable retarded classes	89 to 97%

The research questions raised by this study are:

1. Is perceptual-motor dysfunction remediable?
2. If so, which perceptual development training approach is most effective?
3. Can a perceptual development training program be established in a public school setting, utilizing existing personnel?
4. What effects will such a program have on the child's perceptual functioning, school achievement, and general adjustment?

Work is currently in progress to try to answer these questions. The study is supported by a grant from the Maurice Falk Medical Fund. A manual for the administration and scoring of both instruments has been published by the Pittsburgh Board of Public Education in an experimental edition.

PERCEPTUAL-MOTOR TRAINING: MISDIRECTIONS AND REDIRECTIONS

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The most enthusiastically accepted recent innovations in clinical and special education have been in the area of perceptual-motor training. Visual-motor difficulties have been noted in exceptional children for many years. It has only been in very recent years, however, that perceptual and perceptual-motor problems in personal adjustment and academic performance have been clearly indicated as requiring specific training. For the most part, the emphasis in such practices has been upon visual perception and its association with motoric functions.

Perceptual-motor training may be divided into two basic approaches, gross motor and fine motor. Much more interest has been associated with the latter because of management considerations in clinics and classrooms. Among the proponents of "large" perceptual-motor training are Barsch and Kephart. In the small perceptual-motor area the name of Frostig dominates the field, her work dealing essentially with paper and pencil exercises.

A general fault may be found with both types of approaches from the standpoint that they are both translating abstractions from theory and experiment, at best substantiated only partly by empirical work, into concrete educational and clinical approaches.

Another fault that may be found with the current and popular "perceptual" approaches is that they assume that you can "break" global, molar behavior into discrete and distinct units of functioning to be exercised. In each of these attempts to "fractionate," there is a return to the old discredited positions of faculty psychology and phrenology. Such fractionation is arbitrary, artificial, and often inappropriate for the purposes of training.

Most perceptual-motor practices are in error by limiting training to that which is easiest to train. They focus, accordingly, upon very limited areas of behaviors and may deny the handicapped child basic training opportunities which may be more valuable than those provided. Much of the so-called perceptual-motor exercises of the eye/hand drawing type can equally well be provided in the standard workbooks the child has in school and more effectively by work with actual academic work. Much of the gross muscle-perceptual training desired can be provided in good physical education and recreation programs. By such training we are developing skills essential for everyday living.

Far more help will be provided in regard to perceptual-motor training by focusing directly upon problems a child has in coping with his environment, whether they be physical locomotive or desk-bound ones, than by proceeding down a trail of arbitrarily established training programs which are not really relevant to his needs.

EFFECTS OF FAMILY LIFE ON CHILDREN'S ADAPTATION TO FIRST GRADE

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For the past five years the authors have been carrying out a study of social adaptation, mental illness, and family life of the first graders of Woodlawn, a circumscribed Negro neighborhood of 81,000 people in Chicago. The first goal of this project was the development of a system for periodic assessment of mental health needs among the 2,000 Woodlawn children who enter first grade each year. This system for assessing need was the basis for developing and then evaluating a community-wide mental health program of prevention and early treatment. The assessment system measures periodically the adaptation to the role of student and the kinds and quantity of psychiatric symptoms in the total populations of first graders. Basic relationships have been studied among classroom adaptational status, psychiatric symptoms, and characteristics of the families of the children.

The children's adaptation to first grade is rated by their teachers, using scales of adaptation based on the teacher's own language. Communitywide assessments of classroom adaptation have been made for several consecutive years, based on teachers' ratings made at the first report card time, in the middle and at the end of first grade, two years and five years after first grade. Clinicians make ratings of

psychiatric symptoms, without knowledge of the results of the teachers' ratings, at the time of the first report card in first grade, at the end of the first grade, and at the end of third grade. The clinicians use scales which measure such symptoms as anxiety, depression, bizzarreness, etc. In this overcrowded community roughly 70% of first graders start each year maladapting to the role of student. If nothing is done about it, these same 70% continue to fail and run a high risk of later emotional disturbance.

This paper is concerned with the differences in family life among the adapting and the maladapting children. The systematic family surveys have been done on large random samples of mothers or mother surrogates of first graders. The interview schedule for each survey contained approximately 200 precoded questions organized into major dimensions: the child's relationship to his family and the family's relationship to the community. In addition, six categories were formed representing various aspects of family functions and characteristics: affectional resources; wealth; physical and emotional well-being; decision-making and limit-setting in the family and in the community; respect of the family for the child; and value orientation. Each of these categories cuts across the two major dimensions, e.g., there are a number of questions concerning decision-making within the family and a number of questions concerning the family's participation in the decision-making in the community.

The family constellation of the child which is included in the category Affection, Child-Family is an extremely important factor in successful adaptation to school. Roughly only 41% of families of the Woodlawn first graders have both mother and father present. As a general rule, the remaining 59% of the families have far more maladapting children than do the intact families. There are exceptions, however. It appears that the presence of the mother and the addition of an interested female relative in addition to the mother is an equally effective family constellation. For example, about 3% of the first graders live with mother and grandmother, and these children do as well as children in intact families. Mother alone (37%) or mother with a stepfather (4%) are relatively ineffective in supporting the adaptation of their first grader to school. Various other family constellations have been studied and ranked as to their relative effectiveness in promoting adaptation to first grade. This paper will focus on these studies of family constellations and adaptation to first grade. In addition, an overview of other areas of family life will be described in terms of the relationships to adapting to school.

About 32% of first grade mothers are on ADC and 85% of their children are maladapting to first grade. Premature birth and the mother's health during pregnancy are factors influencing the child's adaptation to becoming a student. The mother's mental health is highly related to her child's success. Twenty-two percent of the mothers rated themselves as very often nervous and tense, while 9% rated themselves very often depressed. All of these mothers had children who were more maladapted. The amount of income of the family is highly related to the child's adaptation. Twenty-five percent of the families live on less than \$3,000 a year. The hopes and expectations of the mother and her own feeling of potency are im-

portant in influencing her child's future. These plus a whole host of other factors could, with adequate planning, be included in a general adaptational response system for better adaptation of children to school.

Our communitywide early assessments of adaptation to first grade and our studies of psychiatric symptoms and family life have provided a target for prevention and early treatment for school mental health programs and could provide the basis for a comprehensive health, education, and welfare response system oriented toward prevention and early treatment. Such a synthesis and reorientation of human services, in our view, would need to be carried out under a neighborhood community council made up of local community citizens rather than agency professionals.

CONTRIBUTIONS OF A GHETTO CULTURE TO SYMPTOM FORMATION: PSYCHOANALYTIC STUDIES OF EGO ANOMALIES IN NEGRO CHILDHOOD

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The present study was initiated in a ghetto school as part of an exploratory investigation of the contributions of "culture" to the phenomenon of "retardation." One of the primary questions has been whether the inordinate incidence of academic failure is (only) symptomatic of social pathology or whether it is symptomatic of pervasive psychopathology, i.e., in the damage or impairment of general/discrete ego functions of the children affected.

An educational survey of two representative grade levels in this school established that 87% of the children failed to meet national reading norms, an incidence 37% greater than average. Some retardation has been so severe that a small percentage of children are graduated into junior high school sans ability to read or write. Our most authoritative informant estimated that some 25% of the children were "uneducable" under present circumstances of both children and educators.

At the start of our two-year consultation, the first grade was selected to obtain a clearer view of the children's functioning before any circularity of school failure obscured their presenting capabilities and motivation. Of some 150 first graders, 40% had been designated as academically unprepared and were placed in two special classes (one of which asked for the consultative study that followed). Twice weekly observations of the class were followed by extended assessments with the teacher as to academic and social functioning, health issues, family fragmentation, sibs, etc. While census tract data reports *only* 30% of the children in one-parent families, this class had twice that incidence. Contrary to expectations, over half the class had one or more years of prior school experience, in either kindergarten or a prior first grade placement—a few had a third year in early Head Start projects.

Minimal but consistent hyperactivity and restlessness were striking; yet there

were no reported or observed incidences of classroom temper tantrums, rages, or aggressive behavior disorders. In the context of mild classroom bedlam, some children were apathetic and withdrawn to the point of sleeping in class. A few children appeared to have severe organic mental deficits or autistic disorders, and more than one child was suspect on neurological grounds.

Psychoanalytic study of the characteristics of ego adaptations/maladaptations of selected academically retarded children referred by the school is underway. Since only two children have been in treatment thus far, this paper will be more concerned with research questions than with tentative conclusions as to cultural contributions to symptom formation.

Data obtains from educational reports that initiate diagnostic study, with subsequent comprehensive pediatric workups and such special supplementary clinical studies as are pediatrically designated. Psychometric and projective batteries and independent psychiatric assessments provide the preliminary screening, prerequisite to acceptance for analysis. (The saliency of the first sample selections have been clear in the manifest and relatively severe ego dysfunctions and academic unpreparedness.) Parents are seen regularly for additional data as to contemporary and developmental history. Daily analytic notes are summarized for consultant consideration, evaluation, and feedback.

Preliminary data analysis indicates that however grievous the inadequacies of later school options, the kindergarten and first grade child of the ghetto is even more disadvantaged in his biological, social, and emotional nurture. Compounding individual vulnerabilities to developmental-maturational stresses are the chronic overstimulation and pervading instinctualization of the milieu. School failure, as a provisional finding, seems one of the shared sequelae of both developmental and contemporaneous stress on the inadequately protected ego. Our observations support the conclusions of a 1967 New York State Legislative Committee's school findings, that much that is described as "retardation" is more a psychiatric than an educational problem.

THE EMOTIONAL SETTING OF THE CLASSROOM

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The emotional atmosphere or climate of the classroom in our primary and secondary schools is created primarily by the composite behavior and attitudes of the students and educators who work together in those classrooms and schools. Secondly, the emotional climate is influenced by the behavior and attitudes of the student's parents and by those who govern and administer the affairs of the town, county, state, and country of which the students and their parents and teachers are constituents. Attitudes and behavior of the community are reflected in the bricks and mortar pro-

vided for education as well as by the economic and professional opportunities provided for the educators. In this presentation the main emphasis will be directed toward that part of the psychological environment in the classroom that is established by teachers and their students, commenting on secondary factors as their significance becomes visible in the classroom. In this context the professional development of the classroom teacher will be examined in the light of our crisis in public education.

PSYCHOANALYTIC REFLECTIONS ON THE EMERGENCE OF THE TEACHER'S PROFESSIONAL IDENTITY

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We live in times of emergency. An emergency can overrun us and cause us to move away from professional and scientific issues, to meet the emergency merely and exclusively as a political emergency. One may, however, also look at emergencies as growth conflicts in the formation of the teacher's professional identity. When was there, after all, ever a time for professional growth without serious social crises?

As we watch a teacher grow and follow his training, starting with his learning history even in very early childhood through college and professional training, we see that professional identity formation is a slow and painful process, a difficult search. One might well speak about—to paraphrase Erikson's term—an epigenetic scheme of the formation of professional identity. This epigenetic scheme would include the ordinary patterns of identity formation but has to be extended to include the profession-specific problems of conflict resolution and adaptation which the teacher must master.

It is interesting to observe how the teacher, as he starts his career, lives through once more all the stages of development he did when he was a child, and we might suggest that he acquires once more, though on a higher level, what could be called *professional ego virtues*. We must be reminded of the teacher's trust in himself and the student, his acquisition of professional autonomy and inner discipline, and the conflicts that he goes through as he attempts to acquire appropriate initiative and capacity to work. He comes to these moments in his development where he must bring about an equilibrium between professional distance and the capacity for sublimated intimacy which is so important if one wants to understand children rather than merely condition them.

Small experiments in teachers' postgraduate education have given us more insight into the applicability of psychoanalysis as it is concerned with problems of learning and teaching.

As we develop the concept of *teaching readiness*, we come to see that psychoanalytic principles can only be introduced at a level where the teacher is ready to

move beyond mere technical and subject skills and make the next step in the formation of professional identity, the capacity to really initiate learning processes and to participate in them. One might well speak about *the second education of the teacher*, the first having taken place usually on the college level, the second having to take place on a professional level of inservice training. The problems of inservice training, staff supervision, and staff instruction are typical for a new phase of maturity for the teacher.

This development of the teacher's professional maturation is beset by many difficulties, such as the social pressures of our time, which have sometimes thrown him back and occasionally even thrown him out of the teaching process when he felt that he could defend his identity and his security only if he were to interrupt the teaching. Psychoanalytic insights into the problems of the administrator, the teacher, the parent, and those in the community who have a lively and active interest in education can contribute not only to the solution of the crisis of public education but may actually turn this whole struggle into an opportunity.

May we think then of the current social and inner dilemmas of the teacher as crises which may turn into growth crises, an emergence towards a professional identity which contains not only teaching techniques but also insight into one's self, the child, and the parent, so that the teacher's activities may be led by his wisdom and guided by his love. Learning for love may then turn into the love of learning; and teaching in order to make a living will turn into love of teaching for a better life.

ANOTHER SCHOOL MENTAL HEALTH PROJECT: PROMISING AND SOBERING FINDINGS AFTER TWO YEARS OF INTENSIVE WORK

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Findings are reported to date of a study of an entire grade (160 children) in a New York City public school after more than two years of intensive psychological study and clinical observation from time of entry into first grade through mid-third grade. Data are presented on a group of disadvantaged and advantaged children showing moderate to severe disturbances of learning and/or social adjustment as suggested by psychological test evaluation, observations in classroom, home and psychiatric interviews, and teachers' evaluations.

Almost 45% (over 70) of the children in the study showed what appeared to be significant difficulties in one or more areas. Most frequently found (approximately 25%) was depression (and depressed withdrawal), the primary descriptive term for 19 children. This description was prominent in 19 other children where another term was used as the primary description. Learning disorders, the next most fre-

quent problem, occurred in 32 children (7 as primary, 25 as secondary); behavior disorders in 26 children (16 as primary description, 10 as secondary) anxiety reactions in 28 children (16 as primary, 12 as secondary); and 14 children were described as having thinking disorders (11 as primary description, 3 as secondary).

As an early report of a project still in progress, some appraisal can be offered about apparent effectiveness of the simultaneous approaches tried (including indicated medical care, remedial speech and reading help, direct therapy with children and their siblings, counseling with parents, parent meetings, and regular meetings with teachers). While some of the widely recognized approaches to preventive and corrective mental hygiene are clearly helpful, immersion in the actual work with this group of children and their families has led to sobering realizations of the magnitude of the problems, which extend far beyond the range of correction by even a generously staffed, hospital-based school health program.

Our most promising finding is that a routine, preliminary survey of all children and their parents at the time of school entry serves as a nonthreatening introduction to the mental health team without singling out as "troubled" any children or parents. It also tactfully introduces the principle of positive mental hygiene and an awareness of normal challenges presented to children as they begin school and are more separated from home. The wide and early acquaintance with the children in the school also facilitates collaborative work with the school (teachers, guidance counselors, and administrators) and enables preventive and corrective efforts to begin early in the first grade. It is believed that obstacles to intervention are lessened, when problems are recognized by school or parents, because of the earlier contact with all the children and their parents as well as because of the working relationship with school personnel which has been established.

PARENT PARTICIPATION IN A COMMUNITYWIDE MENTAL HEALTH PROGRAM FOR FIRST GRADERS

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Several unique forms of parent participation in a communitywide mental health program of prevention and early treatment in an urban neighborhood in Chicago are described. The nature of the group process of these meetings—which involve the first grade children, their parents, teachers, and mental health professionals—is presented. The systematic methods utilized in gaining parental participation and the extent of effectiveness in obtaining parent participation are reported.

For the past five years, the authors have been carrying out a communitywide project of study and intervention in the first grade classrooms of Woodlawn, a circumscribed community in Chicago. The goals of the intervention program are the prevention and early treatment of maladaptation and mental illness in the popula-

tion of approximately 2,000 first graders in this community who enter first grade each year.

At present, 10,000 children in all 12 elementary schools of Woodlawn, nine public and three parochial, have been involved in this program. The effectiveness of the intervention program is being evaluated systematically by comparison of the children in six intervention schools with the children in six control schools.

The outcome criteria include measures of the child's adaptation to the classroom, his clinical status and school achievement tests.

Evaluations of the program's impact have shown significant increases in social adaptation and reading achievement. The evaluation system, its validation and results have been reported elsewhere.

The intervention program consists basically of three kinds of group meetings which take place in each of the six intervention schools during school hours. Two of these group meetings involve the strong participation of parents. There is a weekly half-hour *classroom meeting* which is led by the teacher and is attended by all the children in the classroom, their parents, the principal, and other members of the administrative school staff, and a member of the mental health center staff. Three times a year a *parent meeting* for the parents of each classroom is held at report card time and is led by the teacher. The parents, the principal, the key administrative staff, a member of the center's advisory board, and the mental health center professional are the other participants in this meeting. A weekly one-hour *school staff meeting* is the third key group meeting of this program. This meeting is designed to focus on those factors in the social system of the school which either enhance or hinder the first grader's adaptation to his role. In each school this meeting includes the principal, his administrative staff, the first grade teachers of that school, and the mental health center's staff. Parent participation in these school staff meetings has only recently been started.

Three basic systems of invitation developed to gain the parents' involvement in the program: (1) the child's informal verbal invitation to his parents, (2) the written invitation by the teacher and school, and (3) the personal invitation at home. Individuals who offered the invitations, in order of their priority of use, were a mother of a child in the same classroom, a PTA member from the same school, a member of a community organization, or a center staff or other agency member in the community.

The role of the parents in these meetings is that of a key and active participant. They are defined as the adult with the greatest stake in their child's successful adaptation to the student role and in his future. They are encouraged to use the meeting as an arena in which they openly state their view of what may be impeding their own child's progress, that of other children, or of the entire class as a group. In 1967-68, the fourth year of the program, parent participation exceeded that of the previous year—57.6% of children had a parent attend at least one classroom meeting compared to 32.9% of children who had a parent attend in 1966-67.

THE JUNIOR GUIDANCE CLASSES—AN URBAN APPROACH TO EMOTIONALLY DISTURBED CHILDREN THROUGH INTERDISCIPLINARY STRATEGIES IN SPECIAL CLASSES IN ELEMENTARY SCHOOLS

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The Junior Guidance Classes Program is a comprehensive effort in several new directions to cope with extensive dysfunctioning found among children of all classes and ethnic groups. It has as its premise that a school, well-organized as a therapeutic community, could most strategically serve to coordinate all available community resources so as to cut down the duplication, fragmentation, and oversight of services for needy children. Our orientation includes the concept of greater involvement of the community in the initiation and delivery of services rather than the unilateral development of the program by the professional staff.

The simple transposition of even the most sensitive traditional orthopsychiatric practices to school settings will neither meet current needs nor probe the depth of school potential. The therapeutic accent must be relevant to the school as a unique culture. In the Junior Guidance Classes Program, selected representatives of orthopsychiatry are central to the curriculum and comprehensive educational process. Similarly, selected trained educators are central to the therapeutic process.

A significant number of children reach latency with vulnerability for emotional disturbance manifested by arrests, maturational lags, fixations, and deviations of ego function despite adequate intellectual potential and grossly intact physical endowment. The emotionally disturbed child who cannot function adequately in terms of his psychobiosocial potential but who can function in a therapeutic educational day milieu treatment setting in the community constitutes the child who is placed in the Junior Guidance Classes Program. Heretofore, these children had no appropriate resources available and were often referred to hospitals and other settings which were expedient but not necessarily a primary therapeutic choice. Their psychosocial disturbances may be mild, moderate, or severe and may be manifested symptomatically as disturbances in some or all of the following functions: cognitive, affect appropriateness, speech and communication, motor, habit patterns, body function, psychosensory adaptation, social and integrative behavior. Each child's comprehensive case study profile provides a holistic approach to his care rather than a fragmented one.

Parents must willingly enroll their children in this program. Acceptance of a child into the program at any given time must not only serve his need, but his presence in a class must not destroy the potential for class viability. Thus our class grouping eschews orthodox diagnostic and etiologic nomenclature, attempting instead to group by virtue of degree of adaptive capacity in areas such as impulse control and anxiety, relationship to peers, adult surrogates and environment, capacity for adaptive speech, motility, etc.

Since the interdisciplinary approach, represented by a clinical-educational team,

is a basic concept in the theoretical orientation of the Junior Guidance Classes Program, an exposure of all disciplines to a core body of knowledge is essential. The development of new specialties within each discipline, in which clinicians and educators learn new ways of utilizing their special knowledge, seems inevitable.

Initiated in 1960, the Junior Guidance Classes Program is now in 135 schools and serves approximately 3,500 elementary school children. As of 1968 there were approximately 275 classes with 400 teachers and supportive personnel, including four social workers, 60 guidance counselors, 11 curriculum consultants, one psychologist, and one full-time and one half-time psychiatrist. In addition, supportive clinical services are available from the Bureau of Child Guidance and more than 20 community agencies. The program is jointly administered by a clinician and an educator with an interdisciplinary supervisory staff. Several of the components that determine the direction of the program are controlled intake, comprehensive health care, supportive services, curriculum for the individual child and his group, team responsibility and team teaching, study of group processes in the classroom, individual and group work with parents, a comprehensive case study, balanced classes, and weekly team conferences.

An extensive NIMH research project supported the major directions of the Junior Guidance Classes Program. Currently, the program includes a spectrum of therapeutic educational services ranging from closed register classes to halfway classes in order to appropriately serve the needs of troubled children. Projected plans include extended day, weekend, and summer programing.

PRINCIPLES OF MENTAL HEALTH CONSULTATION TO A SCHOOL SYSTEM

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The objectives of this paper are: (1) to outline the contract between the Human Relations Service of Wellesley and the Wellesley public schools for systemwide mental health consultation; (2) to outline the kinds of pupil problems encountered in mental health consultation in a 6-3-3, 6,000-pupil-population public school organization; (3) to present the principles employed in the handling of consultation issues; (4) to describe those consultation issues which illustrate the concerns and/or problems of youth in transition; and (5) to list some major consultation themes which have appeared recurrently over the past five years, i.e., extrusion, conflict with authority figures, covert and overt "rebellion." Appropriate illustrative case material will be used.

We will also focus on how we have helped consultees to understand problems of youth as they face them in the school.

From 1963 through the present we have used the same statistical consultation card, which is completed after each consultation contact. The card includes the

usual identifying information and a checklist for our major consultation categories: transition, academic achievement, health, attendance, classroom behavior, peer relationships, antisocial behavior, nervous or emotional behavior, home situation, home-school relationships. Secondly, in addition to the consultation card, there is an ongoing narrative record of each consultation contact. The evaluation of the consultation outcome is reported on the statistical card at completion of each case. Thus there is a longitudinal account on each pupil and each consultee and an assessment of the outcome on each case.

1. Key transition points occur in the educational experiences of the students in the school system—at kindergarten, third, seventh, ninth, and twelfth grades. The key points seem to be related to: (a) specific time and curriculum pressures within the educational system, (b) developmental processes and psychosexual changes within pupils, and (c) attempted accommodations by pupils between external and internal demands and pressures (educational and psychobiological).

2. The ratio of boys to girls brought to consultation during the elementary grades is in the order of 2.7 to 1. However, at the secondary school level this ratio changes so that by the eleventh grade more females than males become the focus of consultation.

3. According to our findings, academic underachievement is the major issue around which pupils are discussed in consultation during the elementary grades. At the secondary level, nervous and emotional problems, antisocial behavior, and attendance, along with academic underachievement, become focal issues. As to be expected, at the secondary level the statistics bear out increased concern by teachers, guidance counselors, and administrators around pupil rebelliousness, conflicts with authority, use of alcohol and narcotics, running away, and sexual behavior. Individual and group consultation are the main methods of approach. As an outgrowth of the consultation program other services have developed: inservice training programs for educators, small group approaches for bright high school underachievers, a "total push" program for one selected elementary school district. Thus the consultation contract responds to and/or initiates change in program according to the needs and expectations of the host institution and the ability of the contractee agency to meet the demands.

THE ADMINISTRATIVE STAFF CONSULTANT AS A RESOURCE TO THE SCHOOL ADMINISTRATOR FOR THE IMPROVEMENT OF INTERPERSONAL RELATIONS

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A new position, the administrative staff consultant, was added to the supportive staff of the school as a resource to the administrator. The primary objective of the

consultant's service was to respond to the principal's concerns as he worked with the human factors in the school setting, specifically those which might lead to improved or enhanced interpersonal relationships between principal-teacher, principal-pupil, teacher-pupil, and pupil-pupil. An intermediate goal was to determine the feasibility of the role in terms of its acceptance and utilization by the administrator.

The present paper is a case study based on the work of one administrative staff consultant with five principals during the pilot year. The data were derived from two sources. The consultant maintained a weekly conference log for each situation; in addition, twice during the year the principals were interviewed formally by the consultant.

The principal-consultant relationship was initiated and maintained through weekly conferences. During the initial conferences, each principal readily identified his specific interpersonal concern. Two principals were interested in developing principal-pupil relationships. The first wanted to inaugurate a student advisory council as a means of rapid feedback on student's feelings and opinions. The second principal saw value in working with a small group of boys "who needed attention." The three remaining principals focused on principal-teacher and teacher-pupil relationships. The active involvement of teachers in faculty planning, in implementing self-evaluation and in developing the affective aspects of interaction were their concerns. The principal-consultant relationship developed around these interests. The consultant emphasized the nonexpert, nondirective and nonevaluative aspects of his role working within the general structure suggested by the problem-solving process.

The consultant as a safe, caring, informed listener became the core of the relationship. The principal was often circumscribed by his position in the spontaneous expression of his opinions and feelings. Sometimes, the consultant's listening involved a reflecting-back, sounding-board process. One principal said: "I like to try out my ideas on you before I put my plan into action."

At other points in the relationship where negative feelings came out, a more caring kind of listening was needed. One principal explained: "It is hard for me to criticize and be criticized." Another stated: "I know I should do . . . ; but it is boring." One of the strongest expressions came from the administrator who said: "I can't talk to a teacher about a teacher. It helps me to unburden to you; I couldn't stand it otherwise."

The second major facet of the relationship was the steady redirection of the principal's attention. Several principals indicated that too much of their time was spent "putting out little fires." They found that the regular conferences reminded them of their basic interpersonal interests and the consultant came to represent in some measure what was really important in education.

At two schools the consultant also cooperated in training projects under the principal's leadership. Occasionally, the role model aspects of the consultant's work came through; one principal observed that the nondirective approach of the consultant had caused him to be less authoritarian in principal-teacher relationships. At other times, when appropriate, direct suggestions were offered for the principals' consideration.

Seventy-two conferences were held during the year; 13 conferences with two principals; 14, 15, and 17 respectively with each of the three other principals. Most conferences lasted from 20 to 30 minutes with a range between five minutes and one hour. Since the consultant was available for a maximum of about 20 conferences, the actual utilization of the service was slightly over 70%. This response suggests that the intermediate goal of role feasibility in terms of principal acceptance and utilization was satisfactorily accomplished.

The primary objective of the consultant's service could only be achieved through implementation behavior by the principal. Did the relationship developed during the conferences lead to principal action which improved interpersonal relations? The available data provided some encouraging clues but failed to offer a complete or final answer. Four of the five principals took action on one or more occasions which brought teachers and/or pupils into a more equal and participatory relationship. The actions of the principals seemed to be a direct outgrowth of their discussions with the consultant.

Although the administrators were encouraged by the responses of the pupils and teachers, the extent to which interpersonal relations were improved or enhanced remains unknown. As the principals evaluated the consultant service, three of the five gave an enthusiastic endorsement and requested its continuation the following year. Two principals remained noncommittal. The principal's view of his role emerged as a crucial variable in the utilization of the service at both an administrative and implemental levels. In general, however, the administrative staff consultant as a resource to the school administrator emerged from the pilot year as a supportive role with sufficient potential to merit further development and more rigorous evaluation.

THE PROCEDURE FOR PLANNING A SCHOOL MENTAL HEALTH PROGRAM

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This paper will describe a methodology for planning a school mental health program and will discuss the relevance of certain types of information assembled for this purpose.

In planning for a school mental health program for the City of Pittsburgh, it was decided to study the 49 census tracts in the catchment area for which Western Psychiatric Institute and Clinic had been funded to serve by NIMH.

Information was secured from the U.S. Census 1960 to rank the population, race distribution, school-age children, female median age, median school years, median yearly income, and marital status of females. Other agencies cooperated in sharing information needed on the number of juvenile delinquency cases, dependent and

neglected children cases, public assistance cases, and illegitimate births. This information was ranked from 1 to 49 to indicate the census tracts containing the highest population at risk.

The Pittsburgh Board of Education supplied information for 22 elementary schools and 7 junior-senior high schools pertaining to attendance rate, unexcused absences, prosecution of families with truant children, nonpromotions, mobility, dropouts, total student population, race distribution, teaching faculty, and census tracts or parts of census tracts that compose a school district. A report for each school district was completed using both the U.S. Census Tract 1960 and school information. These reports served a threefold purpose:

1. They helped us to establish school priorities with the administrators of the Pittsburgh School System.

2. They provided background information for the planning of the school consultation program with principals.

3. They helped orientate consultants with the schools' programs and the neighborhoods.

The data collected has pinpointed the geographic area containing the population with the highest risk. It is our opinion that any school mental health program should give priority to that area which has been shown to have the greatest need for mental health services.

However, as neighborhoods differ so will the needs differ in the development of a school mental health program. Individual programs are completely dependent upon the specific personnel involved and their local manifestations of problems. This study will have served its purpose if only to verify that diversified approaches to mental health programs for all schools in our catchment area are strongly indicated.

A SURVEY OF ELEMENTARY SCHOOL CHILDREN'S BEHAVIOR PROBLEMS

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To determine the number and type-distribution of children who have behavior problems in school, the entire population of elementary school children in Des Moines, Iowa, were rated by their teachers on D. R. Peterson's Behavior Problem Checklist. This checklist is based on factor analyses of teachers' ratings of children on the problems most frequently mentioned in child guidance clinic records (e.g., restlessness, distractibility, social withdrawal, anxiety). It taps two broad dimensions which Peterson calls "conduct" problems (problems associated with the expression

of impulses) and "personality" problems (problems associated with the inhibition of impulses).

The checklist used had 36 items, 18 on the conduct-problem dimension and 18 on the personality-problem dimension. Teachers indicated whether the item constituted no problem, a mild problem, a moderate problem, or a severe problem for the child in question.

The completed checklists were processed by computer and were scored as follows: the number of conduct problems checked, regardless of degree of severity, were totaled to yield a "number checked" score; a weighted conduct score was obtained by giving a score of 1 to each conduct problem checked as "mild," a score of 2 to each one checked as "moderate," and a score of 3 to each one checked as "severe" (later analysis of the frequency distribution of these ratings indicated that the weights used were appropriate—i.e., a "severe" rating was about 3 times less frequent than a "mild" rating). Similar scores were obtained from the personality-problem items.

The results of the checklist scoring were printed out by the IBM machine, showing the four scores for each student, by class and by school. Averages of the four scores were obtained for each class and each school. Thus, it became possible to compare classes, schools, and grade levels in terms of the number of behavior problems manifested by the students. Furthermore, students with a large number of problems on either or both dimensions could be identified quickly.

A total of 24,997 machine scorable checklists were obtained. The average number of conduct problems checked per child was 3, and the average weighted conduct-problem score was 6; the average number of personality problems checked per child was 3, and the average weighted personality-problem score was 3. Thus, conduct problems and personality problems were checked with equal frequency, but conduct problems were checked as being more severe.

The results revealed essentially no differences between boys and girls on the personality-problem dimension. On the conduct-problem dimension, however, boys had over twice as many problems checked, on the average, than girls, at every grade level. There was no difference in number of problems checked between primary and upper elementary grades—i.e., first graders had, on the average, essentially the same number checked as sixth graders. Children in special classes for the educable mentally retarded had almost twice as many problems checked as children in regular classes.

These baseline results will be used in planning and evaluating future programs designed to have an impact on children with behavior problems.

A PSYCHOEDUCATIONAL MODEL FOR PREVENTION

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Mental health planning for school maladjusted children must incorporate prevention programs within the schools, combining the resources of education and mental health. The model that can lead to effective results is one that recognizes that children destined for later difficulties in adjustment and learning can be identified at kindergarten or first grade; that inability to successfully cope with school demands is sufficient stress to create chronic emotional disturbance in low self-concept, poor motivation, and avoidant behavior; and that intervention at this early level may involve curriculum changes as well as changes in attitudes and handling by teachers and parents.

An essential feature of such a program is the recognition that a significant percentage of maladjusted children come to school unable to cope adequately because of dysfunction in cognitive, perceptual, or motor skills representing some degree of immaturity in development. Such children have a higher than normal vulnerability to maladjusted behavior, reacting negatively even to normal expectations but having more severe difficulties when school demands are excessive for their skills, where frustration is frequent, and when criticalness accompanies adult responses.

These conclusions are based on the findings from the Lafayette Clinic Cognitive-Motor Research study, where it was found that 40% of maladjusted elementary age children demonstrated severe cognitive-motor dysfunction associated with learning and behavior problems. This research revealed useful methods for identification of these children, psychological assessment leading to a profile of cognitive-perceptual-motor functioning and intervention involving skill retraining, teacher consultation, and parental guidance. Utilizing these methods at an early age can interrupt patterns of secondary emotional disorder; at a later age these methods can be effectively incorporated into public school special class programs as well as day care treatment programs.

WHERE DO YOU LEARN TO BE PEOPLE NOW—IN SCHOOLS?

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If we are concerned about developing a sensible program of mental health education, it would seem logical to consider a program for children in the schools. Obviously, the formative years are the most receptive time for preventive programs. In addition, as children approach puberty and adolescence they often turn away from

the home and to the community for their answers. The place and the time seem appropriate. The program would appear to be one of strengthening coping skills.

In a changing society, we cannot hope to train for specific skills. We can only hope to facilitate the growth of flexibility and a generalized understanding of the ways of man. If we can anticipate, in general, that which cannot be anticipated in particular, then flexibility will probably be fostered. This may be one parameter of coping strength or even of mental health.

For these reasons, the author began the development of a curriculum in the behavioral sciences last year at the Webster College Experimental School. Weekly sessions of one hour each were arranged with a group of fourth, fifth, and sixth grade children for the 1967-68 school year.

It was learned very early in the year that the usual method of lectures with question-and-answer sessions simply would not do if one's goal were to foster learning that would remain with the children and be useful. Therefore, after about six weeks of experimentation, a method slowly evolved that was frankly borrowed from the general design of most laboratory science courses and also from group therapy with a little simulation game therapy added for good measure.

This approach seemed to suit the children and they began to participate, to learn, and to remember. An experiment or game was presented first and worked out to its conclusion by the children. This usually took a half hour. Most of these were planned so that the entire class could participate. The first few, however, were based on classic experiments in psychology and involved having the children pair off and "try things" on each other. The verbal demands were less with these than with the later lessons. They were also more specific as to result and discussion was less abstract.

After the experiment was finished, a general discussion period ensued. This was usually started by the teacher asking, "What happened?" After results were discussed, the general method used in insight techniques followed. "Do you see what you did? How come . . .? Did you ever notice that before?" This questioning continued until the children had either exhausted the subject or, as often happened in the spring term, the children took the initiative away from the teacher and began planning a followup experiment or game. A constant attempt was made to relate findings to real life and the future experience of the children.

Occasionally there was a day when the children obviously just wanted to talk. On these days, they broke into groups and made up short lists of questions they wanted answered. These were then discussed by the group, with appropriate questions from the teacher. Now and then role-playing techniques were used to settle an issue. These "free days" seemed to appear less and less often in the spring as the students took further control of their direction of study.

At no time was "the answer" given to the children. They made all interpretations of the results of the investigations and worked out all of the "laws of behavior." Occasionally, extra collateral information was provided by the teacher if requested. In spite of this, or because of it, they developed in their own language most of the principles of behavior that were relevant to the question under study. They became

deeply involved, very talkative, very clever at looking for "the reason," and seemed to take their discoveries with them when they left the classroom. They seemed to generalize their insights very quickly by the evidence of their behavior in other classrooms of the school.

As a result of this investigation and the satisfactory although far from firmly proven results, it would seem at least reasonable that children can learn behavioral science. These results, although tentative, do imply that there may be a large field for experimentation that remains relatively untouched. Much work remains in defining goals, method, and content as well as the very real theoretical problem of the validity of any claim that teaching a theoretical and soft science has any lasting effect on the behavior of the students. The development of any curriculum may have to remain in the hands of those who know it best: the social scientists. The subject is complicated and could be dangerous if not handled well. No doubt that is why it has been so consistently left out of the general curriculum of most schools. However, it may well be that the time has come for us to consider the problem, and to begin. Our world may depend upon it.

"THINKING SKILLS"—NEW PROGRAMING FOR AFTER-SCHOOL GROUPS OF COGNITIVELY DEPRIVED CHILDREN

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A "thinking skills" project has experimented over a four-year period with the use of children's games, arts and crafts, music, and other activities as a method of fostering the cognitive development of children from low-income families. The project, conducted in a community center in a suburban low-cost housing project, has included each year four groups of 10 to 12 first and second graders in an after-school program twice a week.

The objective was to demonstrate a new method, incorporated within a social group work program, of helping the many children who are already failing to benefit from public school because their cognitive level is much lower than that of the beginning school curriculum. The program focused on basic thinking skills—visual and auditory perception, labeling, comparison, categories, etc. Plans for each group meeting were related to cognitive level; activities were selected and often adapted or modified to specifically introduce a thinking skill, with increasing complexity over the year. The program could be thought of as supplying the children with the basic tools for elementary problem-solving on a conceptual level.

Advantages of the program were that children were readily involved in "fun" activities unconnected with school (no teaching was done); motor activity was correlated with mental processes. Also, content was based on the local environment. Group process was used to help children, especially those with disruptive behavior and short attention span, toward improved group adjustment.

Evaluation methods included pre- and posttesting of experiment and control groups, and staff-teacher rating scales. Findings were favorable, indicating particular impact on the more deprived children.

The program is seen not as a "cure-all" but as supplemental and supportive of school and other programs. It is suitable for community centers and settlement houses, day camps, and other group settings which utilize the same type of activities. It does not require special material or equipment. A manual of activities and methods is in preparation for use by professional and nonprofessional group leaders.

STRUCTURED GROUP PSYCHOEDUCATIONAL THERAPY

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This paper presents a new modality—structured group psychoeducational therapy—for the treatment of children with school behavior and learning problems. The goals of treatment, the role of the therapist, and the techniques employed in this modality are described. Specific applications of the theoretical approach are presented.

The report is based on work with several groups of children with moderate to severe behavioral and learning difficulties. Three age ranges, representing the three age clusters in elementary school, are described. Criteria for the effectiveness of the therapy consist primarily of observable behavior changes in the school setting. Other important outcome indicators include shifts in attitude and approach to learning and performance; e.g., increased acceptance of responsibility for one's own learning, reduced blame projection, increase in the repertoire of roles leading to a more functional participation in learning.

Dysfunctional classroom behavior is dealt with in the psychoeducational group primarily by the special way in which the therapist's role and the task situation are structured. The children are in effect presented with a situation in which discrepancy is structured. That is, school materials are used and tasks are presented to the group but no skill guidance, tutoring, or grading is offered. Work directions are given briefly, in a general rather than detailed fashion, and are usually directed to the entire group. Instead of reiterating directions, lecturing, or correcting, the therapist comments only on the interpersonal transactions. In general this is a confronting type of approach in which dysfunctional behavior with its associated affect and feelings can be directly and openly recognized. The behavior of the child in the group may be commented on but the therapist does not promote or discourage the child's style of response. For example, babyish, cute, or apathetic behavior may be recognized as such with the therapist focusing on the group's reaction to it. This process provides an opportunity for insight because its aim is not to control or avert the behavior.

The therapist openly recognizes with the children that they are in the group

because of their school learning problems but declines the role of "teacher" or "tutor." The emphasis is on the children's choice-making and the development of new roles and behavior in the learning situation. The therapist in this structured approach to group process repeatedly confronts the group (and individual children) with their own "deciding" and feelings about the task at hand.

Communications around the task can vary considerably. The focus may be, for example: disagreements among the children about how to do a particular worksheet that has been presented; an attempt by one or more members to force the therapist or group member to act like a teacher or parent; or the disruptive behavior of a child interfering with another who is working well. Communication process, verbal and nonverbal, is continual and revolves around the very common discrepancies between stated intent and actual behavior as the children deal with tasks. "I want to work but no one will start" is a good illustration.

This modality provides setting, content, and group process which produce a "field" more similar to the classroom than is the case with more traditional group psychotherapy or therapeutic tutoring. This facilitates the transfer to the classroom of functional behaviors learned and experienced in the structured psychoeducational group. Children in the reported groups have shown more functional behavior in learning new material. They have experienced better interaction with peers in and out of the formal learning setting at school and in the group. In addition, a positive correlation exists between length of attendance in structured psychoeducational group therapy and improvement in basic skills and grades.

BEHAVIOR MODIFICATION, GROUP PROCESS, AND ATTITUDE OF GROUP MEMBERS

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Behavior modification methods have been used with increasing frequency in work with exceptional children. Most studies in the literature report on the effectiveness of the method in achieving behavioral changes in the classroom. This paper reports on attitudes and perceptions of class members whose behavior had been significantly changed by behavior modification methods in a group situation.

Subjects consisted of a group of disturbed delinquents in residential treatment. The use of group consequences was based on the assumption that the peer group is particularly powerful in determining behaviors of the constituents of delinquent groups and that group behaviors would be easier to affect than changes in individuals without the group sanction.

This probe, using a structured interview, asked Ss to report their opinions and perceptions of being taught under behavior modification methods. They generally reported it to be a rewarding and psychologically satisfying experience. Methods of teaching and handling management problems were perceived as fair and very helpful.

The smallest children and those who were not leaders according to a sociometric analysis liked the procedures the best. They felt that explicitly working with group contingencies were important, since the smaller children were afraid of the bigger children and were reluctant to displease the larger boys by adhering to school regulations. The group leaders and those most skilled in academics liked the procedures the least.

While it is possible for sharp discrepancies to exist between attitudes and behaviors and for children who learn very little in school to value their experience and vice-versa, it seems most desirable to set schools up in such a way that children can learn and maintain high morale and positive feelings about learning and their experience in school.

The interviews conducted during this study indicate that behavior modification procedures are viewed positively by Ss. The methods not only can enhance learning and behavioral changes but also can be conducive to high morale and positive feelings towards school.

THE WHORFIAN HYPOTHESIS AMONG THE POOR

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Our lowest income children often speak a dialect other than Standard American. They often show below-average school achievement and preference for concrete rather than abstract intellectual operations. The poor academic performance has often been blamed on the use of a minority dialect; many curricula efforts have been directed toward "correcting" children's speech so as to "enable them to think."

This causal hypothesis, that preference for a minority dialect inhibits abstract thought, is a distortion of the Whorfian hypothesis and an ineffective solution for highly complex problems. Drawing on evidence from the fields of anthropology, linguistics, and cognitive psychology, relationships between language and thought are reexamined. Central theses developed in this paper are that:

1. Abstract thought is a universal phenomenon, common in all cultures.
2. Abstract thought depends upon the manipulation of symbols.
3. Symbols are comprehended and manipulated idiosyncratically.
4. Symbols may be couched in Standard American, any other dialect or language, or any other symbol system (for example, colors and mathematical writing).
5. All languages are highly flexible and easily add or modify terms.

6. The sense of elegance (wisdom) and the areas of experience where abstract thinking is considered appropriate vary considerably from one culture to another.

7. Most thinking, especially that of children, is not abstract in the Piagetian sense.

8. Except when used as a symbol system for abstract thought, language communicates thinking more than it shapes it.

Although preference for a minority dialect will not keep a man from reasoning abstractly, it will keep him from obtaining prestigious employment as long as the American economic marketplace operates as it does today. Minority children should be taught the dominant dialect not as a key to abstract thinking but as a skill requisite for better employment. They should also be helped to develop fluency in the types of thinking necessary for success in our highly industrialized economy, whether or not such thinking is stressed in the mother culture. It may be that distinctive styles of reasoning develop among our minorities but, whether or not this is so, how their cognitive styles differ in degree or direction from those of the dominant group remains to be discovered; research is urgently needed.

Although cognitive differences between the cultures may exist, a teacher works with a group of individuals each of whom approximates the norms of his culture only somewhat; teachers must learn to individualize their instruction far more than is now common.

Educators who have chosen the use of a dialect as the solution for profound educational problems have chosen a superficial, ethnocentric approach to social change. Rather, we must learn to perceive as our minority students do; we must help them come to terms with the complex, ever-changing world which often bewilders us.

CHILD HELPS CHILD AND BOTH LEARN

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In keeping with its role of preventing mental illness in its catchment area, Maimonides Community Mental Health Center has focused on the development of school programs for the past three years. The daily experience of our learning clinics with both learning and emotional problems of children demanded a more careful look at the causes and effects of failure in school as it affects these problems.

Our past programs were designed to check failure by dealing with reading disabilities and their underlying perceptual dysfunctions. We not only provided diagnosis and treatment ourselves but we moved out to train teachers with our methods, then to parent-tutors, and finally to student-tutors, a program discussed in the present paper. All of these programs are being expanded.

We decided to study the nature of failure at the beginning of the child's school

career—to attempt to check it, if possible. A concept of development in children is discussed as the theoretical basis for our demonstration study. Levels of development in their relationship to programed instruction in school are emphasized, beginning with readiness for perceptual learning and extending to an intersensory reading method described in the paper.

A battery of group and individual tests were administered to two first grade classes, one experimental, one control. These tests were essentially diagnostic in character, and on the basis of their results an educationally therapeutic program was developed for the experimental group. In this group, the lowest on the developmental readiness scale were identified as requiring training in perceptual-motor skills basic to academic learning. Such a course of training was reduced to a programed series of tasks, and sixth grade children were taught to work with the first graders in circumscribed areas on a one-to-one basis in the classroom while the teacher was occupied with the majority of the class. The sixth graders, boys and girls, were chosen not on the basis of their academic records but on how they were thought to be able to relate to first graders.

The training given theme was programed in terms of specific tasks to meet developmental needs: Some became "visual experts" (visual discrimination and memory); some became "auditory experts" (letter-sound discrimination and blending with the use of the Pollack Phonic Readiness Kit); and still others became "kinesthetic-motor experts" (manuscript writing). Equally important during these sessions were discussions and role-playing involving attitudes and relationships.

In addition to tutoring done by the sixth graders, the entire class of first graders was given a gross motor program emphasizing balance, rhythm, and directionality, as well as the Intersensory Reading Program, an intensive phonic method with linguistic spelling patterns. It taught the child to read, write, and spell with the same vocabulary through simultaneous use of several sensory modalities.

Since the study is not yet complete, objective results are not available. Empirically, however, principal, teacher, parents, and clinical staff attest to the absence of failures among first graders and to the therapeutic value of the experience among the sixth graders.

APPROACHES LEADING TO PREVENTION OF EMOTIONAL DISTURBANCE IN CHILDREN IN RURAL SCHOOL SETTINGS

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The paper is a description of an "active" consultant educational recycling service in five rural towns in the vicinity of the University of Connecticut. The purpose of the paper is to describe typical cases encountered by the consultants as well as to emphasize the rather unique problems that one encounters in a rural setting. It

shall become obvious through the issues discussed that an "active" consultant in a rural area cannot afford the blinding luxury of tenacious adherence to one particular theory for modifying behavior. Some insights into the different methodologies used with these children are discussed.

Data collection involved intense observation of the student in his total environment, standardized testing (when deemed essential by the consultant to provide further insights into the case), and anecdotal comments by the teachers and staff.

This program appears to have helped many children. Of the some 35 original referrals, 15 have displayed a complete disappearance of symptomatology while all have shown positive behavioral change. It is the authors' contention that these changes can be directly attributed to the success of the program rather than to any artifact such as statistical regression. Four typical cases supporting this contention will be discussed in some detail since they underscore the necessity of an eclectic approach with children and the value of an inservice training program with teachers and staff.

The conclusions that have been drawn from this program are these: (1) The employment of "active" educational consultants is a beneficial adjunct to any school program. (2) A rural school setting suffers from the same types of emotional deprivation as the typical inner-city. (3) This deprivation precludes the possibility of a singular approach with all children. Rather, an eclectic approach which exhausts all possible avenues with each child appears to be the only feasible one when all the realities of the situation are taken into account. (4) An inservice training program with teachers and staff, stressing techniques of early identification of children with difficulties and sensitivity to the needs of children, can prevent many problems before they seriously impair the child's behavior and performance. The approaches have to involve an "active" participation by the consultant if he is to be highly effective in communicating with the staff.

THE ALIENATED JUNIOR HIGH SCHOOL STUDENT: A RESEARCH EVALUATION OF A PROGRAM

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The research reported in this paper was designed to develop and evaluate a program for "alienated" junior high school boys. Alienation was described as not accepting the mores and values of the school system. The trait of alienation was determined by an apathetic attitude toward school as well as a history of disciplinary infractions and poor cooperation. Other indices of the trait included limited motivation, a lack of academic drive, and the expressed desire to drop out of school when legally possible.

The specific role of the authors was to assist in the development of a school

program to "reach" the boys. Selection of subjects and program evaluation were additional important functions.

Initially, screening consisted of behavior ratings on 125 boys by their teachers. Additional testing included the Catell 16 PF and the Sentence Completion test scored for alienation and affiliation. In reviewing these data those who appeared emotionally disturbed rather than alienated were excluded, since the school program was designed for the student with social-cultural problems rather than those of psychogenic origin. By using this criterion, 10 students were excluded. The remaining 115 students all became potential candidates for the special program.

Of the 115, 13 boys were selected for the program. An additional 13 students, matched with the treatment group, were used as controls. For both treatment and control groups, testing was administered in September, January, and June of the school year. The program was evaluated by treatment-control group comparisons and by test-retest comparisons within the treatment group. Criterion variables included: (1) absenteeism data, (2) STEP achievement data, (3) Sentence Completion data, (4) 16 PF data, and (5) behavior rating scale data.

The findings of the first evaluation (January testing) were not generally encouraging. Most of the data suggested positive movement for the treatment group; such movement, however, was not statistically significant. The only areas where significant change was noted were in the sphere of personality. These results were interpreted as the framework of more striking changes anticipated by June.

The final evaluation (June testing) verified this prognosis. All criterion variables evidenced significant positive movement for the treatment group. The most striking changes were measured by the 16 PF, the Sentence Completion, and the STEP achievement. Most important, the findings suggested: (1) an overall more positive adjustment in the sphere of personality, (2) significantly less alienation for the treatment group, and (3) marked increases in school achievement.

The personality change appeared related to a positive classroom experience where the students felt involved and confident in making decisions about themselves and their environment. These changes were also clearly related to a group counseling experience which was integral to the program. The marked increase in measured achievement was also very important and it appeared to have occurred as a function of the personality changes.

While the findings should be interpreted by the program staff as an index of success, the results must be carefully presented. At the present time the long-term effect of the program cannot be discussed, but a followup of all treatment and control Ss is being conducted.

Over and above the effect of the program on the students, the research had a favorable impact on the orientation of the administration and faculty. Aspects of this change include: (1) an expanded group counseling program, (2) the initiation of sensitivity training for the faculty, and (3) increased interest to research all aspects of their program.

A PROGRAM FOR THE MOTIVATION, ENCOURAGEMENT, AND EDUCATION OF THE HIGH SCHOOL DROPOUT

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The percentage of students who are returned to school only to later drop out a second and third time is alarmingly high. The statistics quoted on how many dropouts have been persuaded to return are very misleading if one is thinking in terms of preparing an individual to become a productive member of society.

The goal of a demonstration project reported in this paper was to motivate dropouts not only to return to their high school education but to continue to some type of postsecondary education. The program was primarily academic in nature but included counseling with individual students and parents and coordination with the school and related community agencies.

The group of young people we hoped to serve were so alienated from themselves as well as the school and community that they were unable to take advantage of the high school, MDT program, adult education, or other training programs in the community. This group included dropouts, those returning from state training schools, and a few referred by the schools as students beyond the reach of presently existing services and resources of the school.

In the attempt to involve these alienated youths in continuing with their education, we had first to help them gain a more positive assessment of themselves and their abilities. This required the development of a curriculum based on individual interests, relevance, and meaning for meeting the challenges of living. We hoped, too, to be able to identify the approaches which would have implications for the school in preventing the alienation which produces dropouts.

A total of 50 students were served the first year (36 boys and 14 girls), 21 having been referred by the local schools and the remaining 29 having been recruited through community agencies.

The instructional program was worked out individually for each student. A student could attend for one subject or for several. It had been arranged for students to receive credit from their original school and to be eligible for a diploma from that school after completion of requirements. Courses offered were English; world, Afro-Asian, and United States history; bookkeeping; record keeping; business math; typing; general math; algebra; Latin; French; Spanish; psychology; general science; biology; ceramics; art; home economics.

Teachers, like students, might work on one subject or several depending on how many students there were. The groups were organized on an interest rather than grade basis, making for a desired heterogeneity of background and expression. The level of academic work was based on the level at which the student was actually functioning although his school-designated grade level may be entirely different. No formal reading testing was done; instead the student was evaluated after having spent a period of time diagnostically with a teacher.

The teaching staff consisted of director-teacher and five paid and seven volunteer

teachers. These were all concerned with identifying each individual's interest and developing an individualized curriculum based on interest as well as needs. Vocational, personal, and college counseling was also a vital part of the program. If indicated, students were assisted in making the transition back to their school or to another educational facility.

Of the 51 students enrolled during the first year 35 maintained some sort of regular attendance while 18 were consistently present; 19 earned from one to five credits toward a high school diploma; three completed requirements for a diploma and were graduated from high school. Of the three graduates, one received a scholarship to a business institute, one was accepted for college matriculation, and the third plans to start college next term.

FOCUSED GROUP DISCUSSION AS AN AID TO BRIGHT HIGH SCHOOL UNDERACHIEVERS

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This paper reports on the techniques and findings of a four-year demonstration project involving 110 bright eleventh grade academic underachievers carried out at the high school in Wellesley Hills, Massachusetts.

In September 1964 a focused group discussion seminar was introduced into the eleventh grade curriculum as an elective subject for eligible pupils. Eligibility included the following factors: (1) a minimum IQ of 115, (2) a record of satisfactory academic achievement in the elementary grades, (3) occurrence of academic failures beginning at the secondary school level, (4) teacher and guidance personnel appraisal and recommendation that the pupil required more than routine measures to enable him to complete high school successfully and gain admission to college and/or post-secondary specialty school, and (5) pupil and parental signed consent. Focused group discussion was operationally defined as small group problem-solving based upon the common factors of pupil underachievement and willingness to participate (signed consent) in the project.

From the outset, the thrust of the demonstration project was aimed not at improvement in grades per se but rather at a change in pupil attitudes about self-worth and satisfactions to be derived from personally meaningful productivity and creativity.

Format: Each course was limited to an enrollment of 12 pupils and consisted of once weekly regular 50-minute classroom sessions for the duration of one semester. The agenda were developed directly by and from the group members as they attempted to explore and to come to grips with some of the reasons for their school-related problems and their plans for more rewarding and effective coping. As expected, each group had its own flavor and style; at times widely different content.

From the beginning and by design the course was conducted by co-leaders, one a mental health specialist and clinician from outside the school establishment, the second, the dean of girls from within the school system. A special seminar room was established, sound-proofed, and furnished with small tables and comfortable chairs. It was agreed that formal grades would be dispensed with; instead there would be an evaluation by participants and co-leaders at the end of the course.

All sessions over the four years were tape recorded and typed, and the contents analyzed for major themes.

Findings: Each course by happenstance had a core of very verbal activists and self-styled "insurgents." These same pupils were involved in social action activities outside the school, generally not sanctioned by school authorities. The majority of those enrolled, however, while complaining about the establishment and authority figures and chafing against conformity, were less inclined to make their protests overt or to discuss their grievances outside the seminar room. About 85% of the total of 110 pupils verbalized at length that in their opinion current high school education is nonrelevant ("it doesn't hit me where I live") and that "there must be more to life between ages 14 and 18 than preparing for college boards and the union card (college diploma)." There has been general agreement among all participants that the factor of pleasing parents and teachers, by itself, does not motivate them toward academic productivity. "There's got to be something in it for me if I'm going to put my guts into the struggle." Money, social status, and physical attractiveness, in that order, seemed to be the values which motivated most of the students over the four years.

Over the four years more eligible pupils volunteered for the course than could be accommodated. This made control groups possible. Although course grades were never established as a criteria of success, those pupils who participated obtained higher grades and had a higher percentage of post-secondary school admissions than those in the control groups. This finding was a bonus.

PSYCHIATRIC CONSULTATION FOR BLIND STUDENTS PREPARING TO ENTER COLLEGE

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This paper describes an eight-week summer program for blind students accepted for college admission, and summarizes the observations of the psychiatric consultant to the program over the past eight years.

The program's evolution is described. Goals included are academic (especially study methods, typing, spelling skills, and theme writing,) social (included dormitory life and travel and other activities of daily living,) and psychological (notably aspects of motivation, prejudice, and culture shock). The psychiatrist's participation in individual evaluation and planning is described.

Sensitivity training groups have been an integral part of the program, with role-playing and sociodrama used in discussion of typical difficulties encountered in adjustment to college. Modifications of technique adopted in these groups are presented. Differences are summarized in students with congenital and acquired blindness, those exposed to local school systems and state institutions, and those with partial versus total visual handicaps.

Themes underlying the group discussions include tendencies to see all problems as related to the handicap, conflicts of mutual prejudice surrounding "the world of the blind," and resentment of dependency and inadequate or unrealistic evaluation and guidance. Some "pathologic" defenses, including ideas of reference, tendencies to projection, varying degrees of depression, and conflicts around dependency are practically universal in this group.

A followup study of 102 students indicates that 41% of this group eventually dropped out of school altogether, 21% have graduated, and the rest are continuing their studies, often taking longer than four years in the process. Yet, a survey of 128 other students from 22 states, who have taken other special college preparation programs, indicated that 80% graduated; and over 90% are listed as having completed two college years. The difficulties in obtaining accurate data, and of assessing the role of the program in "success" and "failure" categories, is discussed.

Psychiatric contributions to the evaluation of such programs are examined; conflicts and limitations are described. Emphasis is placed on the perspective which can be brought to staff members who are often either overexposed through their own similar handicap, or underexposed through lack of familiarity with the special experiences of and resources for the handicapped adolescent.

A GROUP PROGRAM FOR HIGH-POTENTIAL UNDERACHIEVING COLLEGE FRESHMEN

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In the fall of 1967, 24 students enrolled in our intensive study program, 18 male, six female. Their average age was 17.8 years. All these students had experienced academic difficulty in high school or in their first year of college. All possessed academic records so poor that they were not eligible for admission to the university at regular standing. All, however, possessed evidence of unused academic potential and were viewed as underachievers by those in a position to make such a judgment. In all instances, it was judged that the students were not accomplishing up to potential because of psychological barriers to achievement. These barriers took many forms: broken homes, overprotection, family mobility, cultural deprivation due to minority group membership, rebellion against irrational or overbearing parental and societal authority, and/or the use of drugs and marijuana.

The intensive study program was designed to provide the student with an ameliorative experience, combining progressively accelerated academic work with both individual and group counseling and basic encounter sessions. The basic encounter group was the experiential core of the program. The encounter group is primarily a sensitivity training experience in which groups of 10 to 12 students met twice weekly for two hours each session to explore their potentialities and weaknesses in frank and open discussion with their peers. The encounter group is focused upon the here-and-now of group interaction and aims at development of a caring, involved, and trusting relationship among group members. Overall goals for the participants are increased self-understanding and improved skills in interpersonal relationships.

Three innovations in group technique were explored during the academic year: group marathon, sensory awakening exercises, and self-directed sessions (using prerecorded and audiotape materials developed for this purpose).

The effectiveness of the program was assessed through multiple measures, including changes in grade point average, attrition rate, changes in personal and interpersonal values (as measured by standardized tests), and responses to an open-ended opinionnaire at the end of the academic year. The findings were all positive in support of the benefit of such an ameliorative program. Grade averages increased one full point, attrition rate was extremely low, values modified in the direction of increased positive feelings toward achievement, independence, variety, and benevolence and decreased positive feelings toward conformity and specific goal orientation. Responses to the opinionnaire were uniformly positive in evaluation, and 22 of the 24 students indicated that they planned to continue in school the following academic year.

SENSITIVITY TRAINING AND THE REVOLUTION IN EDUCATION: REPORT FROM A FRONTIER

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From the Medieval Age through modern times, our culture has been progressing through a revolution in its understanding of human nature, growth, and education. The result today is a new spectrum of goals, assumptions, approaches, and techniques which take us well beyond conventional notions of therapy and education. Sensitivity training, at one frontier of this revolution, is being used in ways which already are having profound impact upon individuals and institutions. We need to look at some specific examples—taken here from Peace Corps, church, ad hoc, educational, and other groups—and then face some difficult questions about our own potentials and commitments.

EFFECTS AND INTERRELATIONSHIP OF ADOLESCENT CRISIS ON SIGNIFICANT ADULTS AS SEEN AND HANDLED THROUGH GROUP WORK

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This presentation covers the effects of adolescent crisis on the parents of adolescents and on representatives of schools who deal with the crisis in the school or clinic setting. The manner of dealing with these factors and the material from which the data derives comes from a series of groups led by the author under a variety of conditions: (1) a couples treatment group (middle class); (2) a woman's treatment group (middle class); (3) a group of school personnel (school psychologists, counselors, guidance people, teachers) in largely lower-class schools; (4) a group of young psychologists, psychiatrists, and social workers working with adolescents who were mixed economic and ethnic; (5) two groups of adolescents (largely lower class).

The paper deals with changes or pseudochanges brought about in recognizing or perceiving crises and ultimately in finding alternate modes of behavior dealing with adult anxieties as well as adolescent behavior through group work. It is, in fact, a study of the spiraling of panic and the effects of panic on the immediate interrelations of those involved. It discusses the immobilization that takes place in the total family constellation and in the adolescent's work life (school and non-school). This immobilization appears to occur whether the adolescent and his family react to panic by massive fights or flights (or both), whether acting-out or withdrawal is the mode of behavior. It will attempt to show how the essential family dynamics, reactions, and attitudes (overt and covert) are reflected in the particular form the adolescent chooses to demonstrate his or her crisis, and thus how old (often successfully repressed or successfully handled) patterns of demonstrated anxiety in the individual parents are reevoked. These crises play havoc with the parents' marriage relation, with total family relatedness, and with the adolescent's outside contacts. These further shake the adolescent, stirring him to new pathways often destructive to himself.

The findings of the study are that the immobilization brought about in the adolescent and his family (and school) through panic initiated by the adolescent in crisis can be observed through group work with adults in a dynamic and inter-related fashion. The situation is amenable to treatment in groups and through the use of combined group therapy, group dynamics, and specific task-oriented group work. In groups it is easier to see the particular spiraling effects, the reason for

an individual's or family's choice of mode of reaction, and the meaning of these modes of reaction. It becomes possible for groups to bring about amelioration of their own and the adolescent's dilemma where the family gestalt is such that it can release its stake in old patterns of reaction and attempt alternate ones. Immobilization can be stopped and a course of action embarked on.

A further finding is the difference between real change in the handling of crisis by the family and other significant adults and the pseudochange which breaks up the immediate crisis only to feed a later one. These two somewhat hard to discriminate types of change are demonstrated clearly in long-term groups and have some chance of being modified. Where change is not possible because of the family gestalt, the modes of reaction open to adolescents are noted for good and for ill.

It is felt that group work with adults is a useful way to handle adolescents in crises. It especially is useful, regardless of outcomes in actual change, to the significant adults as a way of working through their own anxieties, their own reaction patterns, and their ability to accept the adolescents (in family or school) even when the immediate outcome is not a happy one.

GOALS, INTERESTS, EXPECTATIONS, AND SELF-EVALUATIONS OF LOWER-CLASS AND MIDDLE-CLASS URBAN BOYS

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This study was designed to discover more about the hopes, aspirations, and reality appraisals of "disadvantaged" lower-class children. These life perceptions of the poor were compared to those of same-aged children in a more comfortable, middle-class environment. The contribution of chronological age to the relation between lower-class and middle-class outlooks was also considered.

90 boys ranging from 7-18 years of age were interviewed individually at two summer recreation centers in markedly different socioeconomic areas within the city limits of Philadelphia. The children were randomly selected on a voluntary basis, interviewed in private and asked to respond (orally or in writing) to questions dealing with (1) occupational preferences (*aspirations*), (2) everyday *interests*, (3) life *goals*, (4) life *expectations* (both occupational and personal), (5) estimation of own *abilities*, and (6) total *self-evaluation*. Data was analyzed by chi square comparisons, with age differentiated by these levels: 7-10, 11-14, and 15-18 years. Findings may be summarized as follows:

1. Lower-class boys exhibit considerable ambivalence in their aspirations, "reaching up" to higher-class jobs while at the same time "pulling" manual labor jobs towards themselves. Middle-class boys unequivocally aspire to high paying, prestigious positions.

2. Both classes show relative agreement on what they "would like to do most

in life," except that middle-class boys seem to want to fulfill their goals more ardently.

3. Lower-class boys are significantly less confident about their chances of reaching their stated goals and aspirations than middle-class boys. Whereas the middle-class boy makes little distinction between goals or aspirations and expectations of outcome, this is decidedly untrue for the lower-class youth. With advancing age this disparity between the classes becomes more evident.

4. Lower-class and younger boys indicate a wider range of *stated* interests than middle-class boys. This finding seems more likely a function of compensation for experiential deprivations.

5. Lower-class boys evaluate themselves lower in intellectual ability than middle-class boys, but do not differ in evaluation of other abilities (e.g., leadership, popularity, recreational).

6. Overall self-evaluations ("How do you see yourself as a person?") are lower for lower-class youngsters relative to boys from middle-class families.

The above results indicate that while lower-class and middle-class boys look forward to very much the same things in life, the former are far less confident about attaining their goals. Certainly these findings support the reality-appraisal capacities of less privileged youth, and emphasize the rational aspects of frustration among the lower class.

THE KIBBUTZ AS A FOSTER MOTHER: PSYCHOSOCIAL DEVELOPMENT OF ADOLESCENTS

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The clinical professions have generally preferred minimizing the differences between a child's original environment and any subsequent setting. Thus, substitution of foster family for own family has been favored over any other alternatives when a child's condition required his removal from own home. Evidence is now accumulating that this stance may not be as functional as originally assumed. Some writers have begun to emphasize the possibility that when change is desired a critical attribute of a "powerful environment" may well be its *difference* from the one preceding it. If the child's "problem" began in the natural family, this line of argument would suggest, the solution to it lies in a markedly different structure.

A kibbutz youth group is a very clear example of such a different structure. Within the social system of the kibbutz, which acts as a kind of institutional "foster parent," the youth group is semiautonomous, age graded, egalitarian, strongly work-oriented. In brief, it is very different from the former social milieu of the young adolescents who join it. If recent thinking about "powerful environment" is correct, then this setting should be very effective in achieving changes in intellectual capability, psychosocial adjustment, and values of the young people who enter it.

Several hundred children in kibbutz youth groups were studied in order to assess changes and correlates of long-term residence. They are compared with similar children who remained these years in parental homes. Intelligence, projective, and value tests were used.

The findings generally suggest that the kibbutz can be, and in some settings of this study has been, a good "foster parent." Given children from the slums of Israeli cities and the doldrums of its development towns, the kibbutz youth group seems to promote intellectual growth, enhance maturity, and inculcate the values it holds dear. As social systems, the youth group and the kibbutz within which it is lodged seem to contain the necessary pressures and rewards enhancing development. A discussion of the nature of these positive factors comprises the major portion of this paper.

NEW APPROACHES TO THE SYMPTOMATIC TREATMENT OF MULTIPLE-PROBLEM PREDELINQUENT AND DELINQUENT TEENAGE GIRLS

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This paper summarizes and evaluates two years of experience with Project MIAMI, an action demonstration project with teenage Negro girls, using an interracial staff in the framework of a personal development program, under the sponsorship of the YWCA, and funded by the Office of Juvenile Delinquency, Department of Health, Education and Welfare. The project involved a total of 80 girls, ages 13 through 16, who according to school, police, probation, welfare, and other agencies came from multiple-problem, one-parent homes and showed poor educational personal and social adjustment, thus maximizing their possibilities for delinquency and dropout problems. Approximately 25% of the girls had been involved with the juvenile authorities.

Through the use of group methods, informal educational approaches, and modifications of group activity therapy, the project staff attempted to modify the observable behavior patterns of the girls with the aims of enhancing feelings of self-worth, providing support for personal and environmental problems, picking up educational lags, enriching the girls' cultural and living experiences, helping to establish realistic social values, and upgrading future aspirations. The project hypothesis was that the achievement of these aims would be reflected in improved school achievement and attendance, better peer relationships, greater participation in the community, and more cooperative attitudes toward the authority. Other changes in terms of how girls feel about themselves, their physical self-care, their motivation for work and learning, and the development of leadership qualities were also aimed at. The overall goals of the project however were broader, in that within the framework of the project an attempt was made to evaluate the most effective methods of working with this group of girls and to use the existence of the project to modify some

of the institutional and community patterns of dealing with this group. Implicit in carrying out the project was the goal of staff development for working with the target population.

An evaluation of Project MIAMI at the end of two years work supports the original hypothesis for the majority of the girls. There has been improved school attendance and achievement, improved relationships to peers and authority, improved personal adjustment and self-grooming, decrease of recidivism, avoidance of delinquent behavior, greater feelings of self-worth, and improved overall functioning as reported by school personnel, probation officers, project staff, and the girls themselves. Certain of the approaches used have been adopted in the community for working with this population, and there have been changes in some of the institutional settings dealing with the multiple-problem girls. The approach developed in the project has far-reaching implications for working with underprivileged teenagers.

DIAGNOSIS IN TRANSITION: DEVELOPING ASSESSMENTS OF DELINQUENCY RELEVANT TO INSTITUTIONAL TREATMENT

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As treatment in an institution for delinquent children must transcend formal clinical approaches, methods of diagnosis are needed that will be relevant to the institutional program. In addition to psychiatric diagnosis, a treatment facility for delinquent boys needs to be aware of sociological typologies, behavior theory, and group dynamics. In addition to these, an institutionalized delinquent boy needs to be assessed by the many nonclinical staff people who observe his involvement in program and interact with him on a daily living basis.

Linking the psychological, sociological, and situational views of a boy is especially important at Berkshire Farm for Boys, which organized its entire institutional system to use milieu for treatment. The paper develops the idea that a social worker at Berkshire Farm, having moved beyond his traditional clinical role to responsibility for a cottage unit, is in an excellent position to determine the treatment for each of the boys in his cottage. Seeing the boys both as individuals and as members of groups and being in a position to utilize the perceptions of child care personnel, academic and vocational teachers, work supervisors, etc. as well as the perceptions of the other boys in the cottage, the social worker at Berkshire Farm can distinguish the boy whose delinquency is ego-syntonic, for such a boy will attempt to reestablish his delinquent pattern in this setting. The social worker sifts the evidence and reviews previous psychiatric and psychological reports to make a diagnostic determination. How he proceeds to do this is the core of this paper.

It is the social worker who determines which boy shall be referred for psychiatric

evaluation. The perceptions of the nonclinical staff are evaluated by him (it is organizationally and educationally vital that he is the supervisor of the child care staff of his cottage). The paper cites examples to indicate the kind of behavior which leads social workers to recommend psychiatric evaluation as appropriate (as when a boy who has not appeared to be disturbed gives evidence of depression) and the kind of presenting behavior that does not indicate pathology (aggressive behavior on the part of a nonverbal, lower-class boy raised in an action-oriented community).

The psychiatrist whose evaluations are sought cannot be a part-time consultant in a milieu-based program. At Berkshire Farm for Boys, the staff psychiatrist is a resident child psychiatrist whose double strength is (1) that he is a full-time employee of the institution (and that he therefore knows intimately the strengths and limitations of the program, the people on staff—child care personnel as well as social workers and administrators—and the other boys with whom the referred youngster interacts), and (2) his identity as a physician, which is emphasized to enable him to more easily establish rapport with the teenager who is greatly concerned with physical changes and sexual development and is experiencing associated emotional stress. Such a psychiatrist tends to avoid the labeling of pathology (whatever the psychiatric classification system) and offers instead a description of the problems the boy faces, his strengths, weaknesses, areas of the program which can offer him extra support, special areas of concern, specific attitudes, etc. The psychiatrist's ability to know the readers of the report, as well as the subject of the report, has a great deal to do with his effectiveness. So too does his knowledge of program when he is making recommendations.

The paper illustrates how an integrated program for delinquent adolescent boys utilizes the perceptions of nonclinical personnel, and how these perceptions are evaluated, considered, and combined with those of the social worker-administrator and the resident psychiatrist to present a multidimensional view on which realistic institutional treatment can be based.

SEX EDUCATION FOR DELINQUENT ADOLESCENT BOYS

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Fifty boys committed to the Maryland Training School for Boys in the age range of 12–15 were given a sex education program consisting of 20 weekly sessions of 45 minute's duration. The program was designed not only to impart relevant sexual information and correct misinformation but to influence behavior and to give the

boys some concept as to how sexual behavior pertains to family life and future adult responsibilities.

Of the boys, 65% were from homes located in the inner city of Baltimore. 60% were Caucasian, 40% were Negro. They had intelligence scores, as determined by WISC, ranging from 77 to 120. 40% had been living with their natural parents. 40% came from homes in which there were five or more children. 35% were in the training school for the second or third time. All the boys in this program lived together in the same cottage at the training school.

The program was given by a multidisciplinary committee of adults representing education, nursing, social work, psychiatry, and theology. The cottage parents were active in planning the program and participated in the discussions. The format was that of a discussion group, with the adults and the boys sitting together in a circular area.

Prior to the first session the boys were asked by the cottage parents to write out questions, and from these we determined our starting point. The subject matter for each subsequent class was decided upon by the adult members who met together immediately after each class with the senior author who was an observer/non-participant of each class. These critiques focused on the observable and often subtle indications of anxiety displayed by adults and the boys alike. The cottage parents reported to us their observations and interactions with the boys during the week between classes, thereby giving us a feedback valuable in planning for subsequent sessions.

The psychiatrist was the discussion leader for the first eight sessions, during which the focus was on the anatomy and physiology of both the male and the female. The highly variable period of growth that all the boys found themselves in was used as a springboard for discussion and the boys' interest was captured by encouraging them to share their slang vocabulary with us. Conception, birth, venereal disease, masturbation, perverse sexual behavior, etc. were all subjects introduced by the boys and adults alike and dealt with in response to what seemed to be of primary interest to the boys at any given time.

A member of the clergy was the discussion leader for the 12 remaining sessions, during which the focus was on family, dating, marriage, results and implications of sexual intercourse, manhood, and control of one's sexual desires. This part of the program was more difficult. Our critiques saved the program from dissolving because of staff conflicts or becoming nothing more than a sham because of the adults' use of denial and intellectualization. Once we were able to help the boys talk about their experiences and concerns we again made progress. During the sixteenth session a boy talked of a boy witnessing sexual intercourse between his mother and a number of different men. How a boy must feel in such a situation then became the primary point of discussion. The response was both interesting and productive.

It seemed to us that at the end of the program the boys came to the conclusion that any child whose birth was the result of sexual activity between a man and woman who were only seeking sexual gratification was indeed destined for a difficult

life if not commitment to a training school for boys. Also, we came away from this experience feeling optimistically that at least some of the boys would evolve a masculine identity based on more than sexual prowess.

A STUDY OF AGGRESSION, ACADEMIC ACHIEVEMENT, AND INTERPERSONAL RELATIONS OF EMOTIONALLY DISTURBED BOYS RESIDING IN A HALFWAY HOUSE

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In the attempt to evaluate the effectiveness of a new treatment program for emotionally disturbed boys, we conducted a study designed to assess certain changes in personality characteristics, mechanisms for coping with aggression, academic attainment, and interpersonal relations. This special program, centered in a halfway house, includes many features (e.g., psychotherapy) provided for children undergoing conventional residential treatment, but also greatly extends the amount and kinds of contacts with events and daily experiences ordinarily encountered by children living in their natural homes. In order to qualify for residence in the halfway house, the child should have profited from a period of institutionalization at Bradley Hospital, should have outgrown the program available in the residential setting (which is limited to children under 12 years of age), and should be judged capable of attending public school and benefiting from a period of transition prior to eventually returning to life in the community.

If living in the halfway house, participating in activities of Boy Scouts and Boys' Clubs, and active involvement in other community functions have beneficial effects, they should be evidenced in positive changes in the boys' psychosocial adjustment. The aim of the present study is to assess the effects of this program on eight boys enrolled in the program during the 1967-68 academic year. At the onset of the study, their ages ranged from 12 to 13 years with a mean of 12.6 years. Their Full Scale WISC IQ's ranged from 90 to 107, with a mean of 95.

The procedure consisted of individual administration of the Rosenzweig P-F Study, which measures expression of aggression in response to frustrating situations depicted in this projective test. The examiner also obtained sociometric choices from each boy by asking him to name the boys in his group whom he liked the most and those he liked the least. Choices and rejections within the group reveal such social factors as popularity, isolation, ignoral, and either mutuality or lack of reciprocity of social choices. Ratings of the boys were obtained from their child care workers, group work supervisors, psychotherapists, and public school teachers. Utilizing the Davids Personality and Behavior Rating Scales, the boys were rated on egocentricity, pessimism, distrust, anxiety, aggression, persistence, self-confidence, self-control, and sociability. School grades were recorded at each marking period throughout the academic year. The assessment procedures were first ad-

ministered in October 1967 and were readministered in June 1968 permitting study of: (1) correlations among findings from projective testing, sociometry, clinical evaluations, and academic performance, and (2) changes in personality, social relations, and behavior in the course of this period of residence in a halfway house for boys in beginning adolescence.

Data analyses yield several significant findings in keeping with theoretical and/or clinical expectations, and others that are unanticipated or statistically nonsignificant. In view of the small sample size, and in order to fully utilize the wealth of data available, individual case studies are presented. Thus, this preliminary study should contribute to increased understanding of the kinds of youthful patients who seem most likely to profit from this modified form of residential treatment.

TRANSSEXUALISM IN ADOLESCENCE—PROBLEMS IN EVALUATION AND TREATMENT

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The transsexual is an individual who wishes to live and be accepted as a member of the sex opposite to his biological sex. The sense of identity of the male transsexual is that of a woman but he acknowledges and is deeply distressed by the fact that he is physically male. These are the persons who seek sex transformation surgery (the so-called "sex change operation"). The male transsexual is profoundly feminine in all respects including nuances of gesture, expression, and gait, so that once cross-dressing begins "she" passes without detection in society as a woman. The female transsexual, in counterpoint, is thoroughly masculine in thought, behavior, and sense of identity and passes undetected in society as a man.

Adolescence represents a period of crisis for the transsexual because the normal pubertal physical changes which occur are in opposition to the profound identification with the opposite sex. How he or she weathers this crisis depends upon several factors including his or her own resourcefulness and resiliency, the attitude of the family, and the quality of the treatment received. The role of the therapist is (1) to recognize the condition as transsexualism, (2) provide crisis intervention including family therapy, support, and explanation, and (3) supportive psychotherapy for the patient. Where the cross-gender identification is irreversible, hormonal treatment and support for the patient's wish to cross-dress and assume the social role of a member of the opposite sex is indicated.

The material upon which this paper is based is drawn from the case histories of 20 patients treated at the Gender Identity Clinic, UCLA Department of Psychiatry, during the past five years. The case histories of three adolescent patients are presented in detail to illustrate different problems in management.

Transsexualism must be differentiated from transvestism, effeminate homosex-

uality (or "butch" homosexuality in the case of the female), and biological intersexed conditions.

The diagnosis is based (in the male) on a history of feminine behavior and interests beginning in early childhood (this confirmed by the parents), profound and natural femininity on mental status examination, an absence of masculinity (including no history of pleasure associated with his penis), the wish to live in the social role of a woman, and desire to be "changed into a woman" by medical treatment.

The therapeutic approach depends upon the way the patient has responded to the "crisis of puberty." In one case profound despair and suicidal rumination required that the adolescent be hospitalized. Following the hospitalization the concealed, but conscious, transsexual longings were revealed to the therapist. In another case, a highly resourceful teenager secretly obtained a supply of female hormones and successfully feminized his body by self-medication.

Most often the transsexual adolescent will begin to cross-dress secretly. When this is discovered by parents or siblings, reactions of shock, disgust, and disbelief are not uncommon. Depression or elopement of the patient may be precipitated. It is in these circumstances that family therapy is especially indicated.

Work in our clinic has indicated that when transsexualism is recognized in early childhood, therapy may reverse the condition. However, we and others have found that after puberty the condition is irreversible. No way has been found after puberty to replace the profound femininity and feminine sense of identity with masculinity. The treatment in adolescence following an adequate period of observation leading to correct diagnosis involves the acceptance of and accommodation to this reality.

PRESUICIDAL STATES IN ADOLESCENTS

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The purpose of this paper is to describe presuicidal behavior, emphasizing communication, in adolescents. Data are presented on three groups as follows: (A) all persons (thirty in number) under age twenty who committed suicide in Los Angeles in one year; (B) all teenagers seen at the Los Angeles Suicide Prevention Center during that year; (C) a random sample of teenagers who were seen at the Suicide Prevention Center over a period of ten years.

In Group A, committed suicides, there were 21 males and 9 females. The most striking finding was the discrepancy in the manner in which the two sexes brought their troubles to the attention of helping authorities. All 9 of the girls were known as potential suicides. They had made suicide threats or previous suicide attempts. They had been seen by social workers at juvenile hall or by psychiatrists in private

practice. By contrast, only 2 of the 21 males had been seen by a psychiatrist. One had been seen by a social worker in juvenile hall, and one was in jail at the time of his suicide. Two had drawn some attention to themselves by having several automobile accidents in the month before they committed suicide. The majority of these young men were described as quiet, obedient, often studious, but usually moody persons. In the majority of cases the parents showed shock and inability to understand what had happened, together with great concern. Often the mothers were profoundly depressed by the death.

Persons 19 years and younger make up about 15% of the cases seen at the Suicide Prevention Center. About 70% of the group were females. Only 10% of these youngsters were self-referred, in contrast to the total population of the Suicide Prevention Center's patients who are more than 50% self-referred. The younger male patients (ages 13-16) tended to be neurotic boys whose families were in a state of turmoil. The young men (ages 16-19) tended to be depressed and schizoid or schizophrenic. About a third of the males were rated as high suicide risks. The younger girls also were caught up in family turmoils but the girls seemed more able to bring their problems to school authorities. There were a few depressed schizophrenic girls. The great majority of the females were involved in symbiotic interpersonal relationships and often felt that they had been repeatedly rejected by parents and by men friends. Thirty percent of the young women were pregnant.

In summary, there were fewer young males seen at the Suicide Prevention Center but those that were seen were evaluated as being much more likely to commit suicide. The trend for males to have a higher suicidal rate and a lower communication tendency appears at an early age. Suicidal female adolescents demonstrate their problems to helping authorities long in advance of suicide, but suicidal adolescent males do not. When they are brought to the attention of the Suicide Prevention Center more vigorous action and intervention is required for males. A goal for suicide prevention might be to work for changes in the cultural-educational expectations felt by young men so that they could more easily recognize and seek help for emotional problems.

PRE- AND POST-HOSPITAL CHARACTERISTICS OF HOSPITALIZED ADOLESCENT SUICIDE ATTEMPTERS AS COMPARED WITH OTHER HOSPITALIZED ADOLESCENTS

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Adolescent suicide attempters have been the subject of a number of investigations. Few controlled studies have been done and even fewer followup studies. Most of the controlled studies have used relatively healthy adolescents for comparison to psychiatrically disturbed suicide attempters. We had the impression that some

of the characteristics previously attributed to suicide attempters could be attributed also to the psychiatrically ill adolescent who does not attempt suicide. Our findings support this impression.

In the study reported in this paper a group of 38 hospitalized adolescent suicide attempters were compared to a control group of 38 adolescents who were admitted to the hospital without any history of suicide attempt. The groups were matched for sex and age and compared in several areas of psychosocial adjustment. Most of the patients in both groups were followed over an average period of 22 months and then restudied in regard to many psychosocial parameters. The main sources of information were the hospital charts and telephone interviews.

Prehospitalization Phase: (1) Family Relationships: Essentially the same number of patients in each group had suffered a loss of one or both parents. There was a significant difference in regard to the age of the loss, however. If the age of 12 years is used as a cutoff point, the adolescents in the suicide attempt group lost their parents more often before this age than did the adolescents in the control group ($p < .05$). (2) Social Relationships: Numerous areas of social adjustment in the two groups were compared and essentially no differences were found that were statistically significant.

Posthospitalization Phase: (1) Suicide Attempts: In the suicide attempt group, 50% of the adolescents made at least one more suicide attempt by the time of followup (an average of 22 months after discharge). This was significantly different ($p < .01$) than the attempt rate in the control group (8%) during the same period of time. (2) Family Relationships: Proportionately as many of the suicide attempt group were living with family members as were controls. (3) Psychosocial Adjustment: The suicide attempt group had significantly fewer agency contacts ($p < .01$) and a significantly better employment record ($p < .05$) than the control group. There was no significant observable difference between peer relationships (social activity) or school performance in the two groups after hospitalization.

In summary we think that there are several important features that characterize the suicidal adolescent. One must be extremely careful, however, to distinguish between those features that belong specifically to the suicide attempting adolescent and those features which describe psychiatrically ill adolescents in general.

PHASE DEVELOPMENTAL APPROACH TO SUICIDAL BEHAVIOR

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Various approaches are compared: the cultural/ethnic, such as racial inversion rates of suicide and homicide; the occupational, such as comparing the number of suicides among physicians with the general population; by stages of life, such

as the pronounced rise in suicidal behavior with adolescence; the seasonal, such as the increased rate with winter; the geographic-demographic, such as a study of the San Francisco suicide rate. Essentially, these approaches are statistical and include interpretations of the statistics. Another approach seeks meanings in the forms of suicide. Study of family interactions and family composition is still another approach. Recently a reconstructive method, the psychological autopsy, has been recommended. The use of the personal historical events leading up to the suicidal behavior as analogous with a concatenation of thoughts and actions working to make a dream is an example of the psychoanalytic approach. The analogous approach of utilizing predictive suicidal aspects of interview content as with prophetic dream content has been indicated.

The approach employed here is genetic or phase developmental in its attempt to explain "what interplay of forces can carry a [suicidal] purpose through to execution" (Freud). Suicidal purpose is recognized as unconscious as well as conscious; that is, the suicidal individual may be unaware of a developed suicidal potential, and the suicidal individual does not have to proclaim intent.

The thesis is that a suicidal personality evolves in the course of phases of development from infancy through to old age. Suicidal potential may prevail universally at all ages but is pronounced in the phases of adolescence, climacteric, and old age. Certain individuals, if they do not die in one phase or another, are more vulnerable or prone. Behavior, from autodestructive and autoaggressive to self-destructive, is discussed with illustrations from the infancy period, childhood, adolescence, and adulthood. Essential to the interplay of forces determining the suicidal behavior are the vicissitudes of aggressive drive, ego splitting, and narcissism.

The suicidal purpose is fusion or merging, in a narcissistic sense, with the primary object (parent) "lost" in sado-masochistic conflicts over separation. It rids the ego of the anxiety of splitting and the task of maintaining an intact identity. Loss, abandonment, mobilizes aggressive drive and strains the psychic structure and structuralizing process. The emphasis throughout the phases of development is on the ego's capacity to deal with loss of the object as significant for suicidal development rather than on the aggressiveness of the object toward the ego.

FIRST PREGNANCY AND THE ORIGINS OF FAMILY—A REHEARSAL THEORY

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First pregnancy is a progressive, maturational period in the personal and familial life of a married couple in which "spouses are transformed into parents and a marriage into a family." The full psychological meaning of this stage of development has not been sufficiently appreciated because the view still remains too narrowly focused on the psychological development and emotional health of the woman seen in isolation from her husband as she experiences her pregnancy, delivery, and readiness for the role of mother. Insufficient emphasis is given to the interactive relationships between the wife and husband and the changes that both undergo during the pregnancy in relation to themselves, to one another, and to the transformations of their roles as family members.

Classical psychoanalysis has usefully made visible the past and future orientations of the pregnant woman through her identification with her mother and her child. More recently, the notion that parenthood is a developmental stage enlarged this view by including the father in its theoretical scrutiny—emphasizing that for both spouses confrontation of the regressive and transference aspects of their own historical parenting help prepare them for the anticipated new roles. These views may be extended by focusing on the interplay between man and wife over the course of pregnancy, specifying the characteristic psychological tasks of each of the trimesters and the post partum period, and observing how these tasks bring forth from the couple a variety of roles which they act out with one another. They seem to try out both problem and response, the dependency needs and the nurturance, the fusion and the separation, the maternal and paternal variations of the parental roles, as well as the helpless, unoriented, and unrealistic qualities of the needy infant. Through this stimulation they make their relationship a stage for the tryout of the family roles that they will occupy when the child is born and the family structure crystalized.

This rehearsal theory of pregnancy hypothesizes that such tryout experiences make room for the child by repatterning of the simpler dyadic to the more complex triadic relationship, making his needs and participation part of the family system but not excluding either parent. The vigor of such interplay derives from the vitality of the relationship of the couple. In marriages that are stuck, where the interplay is reduced and stereotyped, pregnancy may create responses of psychological withdrawal or actual abandonment by either of the spouses. In such cases,

there will be a tendency to reinstate in the present the early historical experience of parenting as a substitute for the more appropriate one created by the mutual interactive psychological work of this period.

From the perspective of the rehearsal hypothesis of pregnancy, data is reported from a pilot study of 10 couples going through a first pregnancy—young adult, middle class, well-educated, with no psychiatric or medical histories. Using a clinical depth interview, man and wife were seen separately following the quickening, and together in their home following the birth of the child. A history of early family life patterns was taken; courtship style and problems in adaptation to honeymoon and marriage were established. They were encouraged to talk about present decision-making, mutuality of goals and problem resolution style. Their interactions in each of the trimesters were determined, emphasizing patterns of dependency and nurturance, changes in content and style of communication, sexual activity and its meanings, shifts in division of labor. Fantasies, dreams, and degree of reinstatement of early familial memories and the extent to which these were communicated were also established. Their reactions to the reality of the presence of the child, their expectations, hopes, and anxieties were elicited. Post partum reactions of change towards one another and towards members of their historical family, as well as adequacy of parenting, were the focus of this interview. Attempts were made to assay the nature of the dependencies, the development towards further autonomy, and the emerging family style.

Analysis of the data suggests the discreteness of the psychological tasks of the trimesters and the importance of the psychological presence of each spouse for their mutual development, adequacy of mothering offered to the infant, and changes in adult status. Fears of abandonment and desertion appeared in various forms leading to attempts at reparative measures.

Implications of this approach for prenatal care and psychotherapy are discussed.

A FIVE-TO-TEN-YEAR FOLLOWUP OF FAMILY COPING STYLES FIRST IDENTIFIED IN THE WELL-CHILD TEACHING CONFERENCE

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Long-term followup studies of mental health programs in primary prevention instituted in the past have become increasingly relevant for future planning. From

1955 through 1963 the authors participated in a well-child teaching conference designed to provide beginning medical students with an understanding of family life, child development, and social influences upon medicine. Over a period of one year we were successful in locating 53 and obtaining findings on 46 of the 92 families in the original sample, using questionnaires, telephone interviews, and home interviews. The families were typically white, intact, with 1.7 children including an infant, mother aged 24, and father aged 28 who worked as a technician or skilled laborer. Both parents had some education beyond high school. The families attended well-child conference regularly and owned their own homes. No significant difference between the families participating in the followup study and those not participating was evident except for the higher incidence of home ownership in the participating group.

Each of the families was seen for 15 to 30 minutes once a month during the first nine months of the program. Home visits were made by the student three times in the first year, followed by less frequent clinic and home visits in the second and subsequent years of the student's medical school career. Both parents and students were helped and encouraged to verbalize specific observations on all the children who attended the clinic and to interpret the meaning of what they observed. The physician spoke to the parent through the child by openly verbalizing and interpreting the child's play and interactions with the observing group in the parents' presence. Periodic parent-student-staff group discussions offered parents an additional means of increasing their understanding of themselves and their families and of gaining a more realistic perception of their own behavior with their children.

Both the child's and the parents' coping skills were given as much attention as problem areas. A high level of enthusiasm and interest in the child's and family's development was maintained by the physician and clinic personnel. A coping rating was developed and each of the families was rated according to information obtained during the original period of contact. Predictions were used as a basis for organizing followup data. In approximately three-fourths of the families, average or high-level coping was observed in the present and predicted for the future. The investigator's perceptions of the extent to which the well-child conference was valuable to the parents correlated significantly with the way that the parents perceived the experience five to 10 years later. Also, it was demonstrated that the kinds of services which the investigators thought were most valuable at the time they offered were those which the parents identified as most valuable five to 10 years later.

Except in situations where unpredictable intervening variables produced traumatic situations, we were reasonably accurate in our predictions concerning families likely to remain free of psychopathology. Severe and moderately severe psychopathological development was also reasonably well predicted. In looking back on instances where accurate predictions were not made, it was discovered that we had been seduced by the mother-infant halo effect in which we, as well as our students, were too ready to declare good health or good response to our intervention techniques when there was contrary evidence.

Implications of these findings for the design of other early intervention programs and educational approaches in primary prevention will be discussed.

HIDDEN STRENGTHS IN THE DISORGANIZED FAMILY: DISCOVERY THROUGH EXTENDED HOME OBSERVATIONS

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The work reported here consisted of a series of home visits to several disorganized ghetto families. The goal of these participant observations was to gain first-hand information and insight into the daily functioning of disorganized families. The project was based on the belief that even highly disorganized families may exhibit important strengths in their daily methods of coping and in their interpersonal relationships, and that these positive aspects are rarely revealed in the clinical setting.

Ghetto families coming to the attention of community agencies—in this case a comprehensive health care center cosponsored by Children's Hospital of Philadelphia and the Philadelphia Child Guidance Clinic—tend to present pictures or overwhelming helplessness and hopelessness. Clinic contacts tend to take these families out of their natural setting for brief periods of time, and the treatment situation focuses on problems and pathology. By contrast, it was felt that routine home and neighborhood experiences, shared by family members and a professional observer, might gradually lead the helping professions toward more realistic goals, methods, and communication with disorganized families.

Twelve families studied in over 250 visits, observations taking place within homes, on front door steps, churches, bars, agencies, on shopping trips, at parties and outings, etc. The observer gradually came to know key members of each family's social network and to identify their differential roles and functions. In each such network, one or several persons were noted as important stabilizing forces for the others. Their influence was exerted by way of material aid or—more frequently—through supportive functions in child-rearing, physical care and safety, orderly planning, and morale-lifting. Moreover, members of the nuclear families under observation also were noted to be capable of functioning in planful, sensitive, and effective ways under certain conditions—quite contrary to their reported and actual behavior in the clinical context.

The present paper describes the methods used to gain access to these families and deals briefly with the observer's role throughout these visits. The main purpose of the paper, however, is to illustrate a variety of strengths and coping behaviors observed in the ghetto setting.

While all 12 families studied revealed some coping abilities, the present report focuses primarily on one family and its social network. The Philadelphia Child Guidance Clinic's understanding of this family before and after the series of participant observations demonstrates how naturalistic observations of family functioning within the home and the neighborhood can add significant information and insights to the usual diagnostic and treatment processes. Illustrations from the other families included in the project are provided as supplements to this more detailed case description and analysis.

Multiple and lengthy home observations clearly are not a feasible routine procedure for assessing individual disorganized families. However, it is proposed that intensive study of a limited number of families, including documentation and a systematic search for recurrent themes and behavior patterns, may lead toward bridging the usual communication gap between the helping professions and the more disorganized ghetto residents. A reality-based understanding of some basic needs, feelings, and coping responses is urgently needed if professional services—be these to identified “patients” and “clients” or to larger community sectors—are to find ways of reaching the “hard-to-reach.”

PARENTS' VALUES, FAMILY NETWORKS, AND FAMILY DEVELOPMENT: WORKING WITH DISADVANTAGED FAMILIES

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A pilot project designed to develop methods for influencing the relations between parents and children in culturally disadvantaged families is reported. The methods were designed to move the parents from a less developmental to a more developmental orientation towards their children and towards ideas, feelings, and behavior which lead to the enhancement of the child's competence, i.e., his “capacity to interact effectively with his environment” (Robert White). The project took place in four phases:

Phase 1. Interviewing the key families: Six families were selected on the basis of having a child in the lowest track of the Martin Luther King preschool center, serving a lower-income black housing project community in Chicago. Each parent was given an intensive open-ended interview concerning the attributes which the parent deemed desirable or undesirable in a 4-year-old boy or girl. Mothers were interviewed by a female worker and fathers by a male worker. These interviews, along with worker observations, served as the baseline evaluation data for the program.

Phase 2. Introduction of developmental activities: The workers returned to the homes and introduced developmental toys and games corresponding to those stated aims of the parents which most closely approximated the aims of the project. Worker and parent collaborated to involve the child in the activity with the parent. Older siblings were encouraged to participate in the development of the 4-year-old, and both older and younger siblings were frequently provided with games of their own. The process was repeated until the parents took an autonomous role in the planning of activities and began to utilize the special library of developmental toys located at the preschool center.

Toward the end of Phase 2 it was discovered that the fathers were highly resistant to taking on this child rearing role, and consequently the male worker switched

tactics and brought the fathers together to form the core of a concerned fathers' action group.

Phase 3. Reaching out through the network: The mothers were encouraged by the female worker to interview friends who had children of preschool age and to introduce developmental games to these families. Some 20 additional families were thus brought into the program, at the same time giving the key parents a special leadership role in the community.

Phase 4. Followup (approximately nine months after the beginning of Phase 1): Mothers of the six key families were reinterviewed by a different worker. A control group was also interviewed at this time.

Four of the six mothers showed marked increase in emphasis on the development of competence in the child and upon the importance of the parental role in that development. Three of these four also showed increase in concern with the internal aspects of competence development, i.e., the propensity to conceptualize the child in terms of his likes and dislikes, interests and feelings. In two such cases the mothers placed great emphasis upon the importance of a sense of competence. These were the two mothers who showed the greatest general increase on the competence emphasis dimension. These two were also the mothers who, as a result of the program, had become involved in playing effective roles within the preschool center.

The changes reflected in the interviews were paralleled by the worker's observations of change in parental ideas and behavior.

It is concluded that the most important element in the development of competence in the child is the parent's own subject grasp of the importance of a sense of competence. It is recommended that future programs aimed at making parents more developmental towards their children should include major opportunities for the parents to experience growth in their own sense of competence beyond the family setting.

THE VICISSITUDES OF THE MALE SPOUSE AROUND THE PSYCHIATRIC HOSPITALIZATION OF HIS WIFE

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The short-term therapeutic group project reported in this paper had five objectives. First, to further document and evaluate the impact of a wife's hospitalization on her mate. Second, to provide an avenue of expression by husbands for their feelings about their current crisis. Third, to assist the male spouse in obtaining a greater understanding and awareness of the nature of his wife's illness. Fourth, to make known services and facilities which would ease the stress during the crisis period. Fifth, to determine the value of this group approach on a short-term basis.

The prospective group members were evaluated in individual interviews in which

the purpose of the group was described and the nature of the group contract explained. Eight candidates were interviewed. Six were selected for the group and of that number, four participated in the group sessions. The selection of three of the husbands in the group was made from referrals by the treating therapist of the hospitalized spouse. In each of these instances the therapist was impressed from his contacts with his patient that her husband was in need of assistance. The fourth member was directly selected by the author, who had interviewed the husband when he requested immediate help on the day of his wife's hospitalization.

The material for the paper was provided by attendance of the four members at six group sessions.

The author is impressed with the fact that the short-term group served in fulfilling the stated objectives on several levels. Early in the group experience it became evident that the impact on the husband of the wife's hospitalization was traumatic. This trauma was superficially as well as unconsciously expressed. Mutual aid in group experience allowed developing individual strengths to be utilized in coping with daily stresses.

A short-term experience had several implications for group participants: It facilitated a focus on the immediacy of services. It delineated a set period of time within which goals had to be reached. Fears about their individual crises were subordinated to the task of focusing on and attaining their individual goals.

FAMILY THERAPY IN PEDIATRICS

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Numerous programs have been developed to teach the behavioral and emotional aspects of pediatrics to pediatric trainees. Clinicians in the pediatric field, however, still complain of their own lack of skill in this area of practice.

In our medical center, the authors—a child psychiatrist and a pediatrician—have been acting as a liaison team teaching pediatric house staff the behavioral and emotional aspects of their specialty. Family interviewing has been utilized extensively in the training program. This technique has proven to be very effective, especially in demonstrating the effects of somatic illness on the family group and delineating the effects of individual behavior and family interaction on the course of an illness. The universal coexistence of biological and psychosocial factors in all illness comes to light dramatically in family interviews.

In this program pediatric residents are asked to bring to the attention of the pediatric-psychiatric liaison team any patients who are presenting perplexing problems despite expert medical management. Asthmatic children with recurring severe attacks and diabetic youngsters continually "out of control" are typical examples. The pediatric residents interview their own families in a small conference room

with the family, the resident, the pediatric-psychiatric liaison team, a social worker, and often with one or two fellow residents sitting in. An outline has been developed to help the trainee focus on significant family behavior and interactions. This outline also assists him in developing a sensitivity to and an awareness of the cues and leads supplied by the patient and his family throughout the interview. The resident is instructed to terminate the interview after about 30 to 35 minutes; then one of the faculty takes over the role of interviewer. (In the paper one of these interviews is examined in some detail.) During the postinterview discussion sessions process, content, inferences, conclusions, and the role of the interviewer are examined critically. The trainee and the staff arrive at a working dynamic formulation and identify problems to be dealt with in followup visits. In addition, the effectiveness of the interview is considered and recommendations for an appropriate therapeutic program for child and family are developed.

By observing and participating in these family sessions, the pediatric trainees sharpen their interviewing skills and develop an awareness of their own role in the diagnostic and therapeutic process. They also observe directly the effects of childhood illness on the family, the effects of family interaction on the child and his illness, the meaning of the illness to the child and his family, and the use of the illness by the child and his family. Followup visits with the family in the pediatric outpatient department demonstrate to the resident the clinical effectiveness of his intervention with the family. He is also able to participate in the implementation of a therapeutic program based on his observation of the interactions in the family session.

The authors feel that the family interview techniques and the teaching methods described can be appropriately applied to the training of other nonpsychiatric disciplines.

FOLLOWUP EVALUATION OF FAMILY CRISIS THERAPY

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This study reports the results of a comparison between outpatient family crisis therapy and mental hospital treatment. 150 cases from the same psychiatric population were randomly assigned to family crisis therapy and another 150 to mental hospital admission. The crisis treatment was carried on without hospitalization and consisted of approximately five office interviews, a home visit, and several phone contacts and it occurred over approximately two and a half weeks. Hospital treatment averaged 26 days in a university psychiatric hospital (Colorado Psychiatric Hospital). On admission to either treatment, data were obtained on recent crises and

on the social adaptation of the identified patient. Baseline measures were contrasted in each group with the measures obtained at a six-month followup which was done by independent clinicians. Records of mental hospitalization before and after treatment were carefully tabulated.

The two groups were clearly from the same population as demonstrated by lack of significant distinction on 15 variables (as measured by chi square) as well as the randomness of assignment to treatment. At six months the 150 family crisis cases were functioning as well as the cases treated in the hospital. Functioning was measured by the Social Adjustment Inventory (four subscales and a total score) and by the Personal Functioning Scale (three subscales and a total score). Examination of the posttreatment admissions to mental hospitals revealed that during the six months after discharge from treatment, the family crisis therapy cases were less likely to be hospitalized. Those who did require mental hospital admission remained in the hospital only about a third the length of average hospital stay for those whose treatment had been hospitalization. Return to functioning in the usual role is more rapid with family crisis therapy than with hospitalization.

This report demonstrates that family crisis therapy is effective in keeping acutely psychotic patients out of the hospital. Those treated by crisis therapy recompensate and return to functioning more rapidly than those admitted to the hospital. The followup studies indicate less clinical chronicity of the psychotic process and less family disruption.

ADOLESCENTS AND THEIR FAMILIES

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This paper describes a model for the treatment of symptomatic adolescents and their families which involves a combination of simultaneous family and group therapy. The rationale for this model has implications for understanding the gap between society and the adolescent.

Over a three-year period the authors have been using this approach in private practice with families and their adolescents on an outpatient basis. The adolescents do not enter the group until the treatment of the families (including the adolescent) is well underway, and a condition for their participation in the group is their parents' commitment to continuing in long-term couple or family therapy.

The rationale for this technique is the premise that the disturbed adolescent is the symptom bearer for the family. One particularly important function of the adolescent's symptoms is the protective defensive cover they provide for the parents' marital neurosis. The adolescent, an active participant in the family system, has

his own stake in maintaining the status quo and invites the family's hypercathexis of him.

At referral in all of the cases, the families presented the adolescent as the major if not the only problem in the family, and certainly the only one who required professional help. The symptomatic adolescents, on their part, tended to be highly unmotivated for help for themselves. Insufficiently differentiated from their families, they were poor candidates for either individual or group therapy at that time. Many had long histories of severe acting-out and their parents were seriously thinking about placement. The beginning phase of treatment involves working with the family towards reducing their overattention to the adolescent. It is only when the parents are ready to focus more on themselves and their marital relationship that the adolescent, no longer so deeply embedded in the family ego mass, moves into group therapy.

Clinical vignettes are presented to demonstrate (1) the parallel process involved, (2) how issues such as confidentiality are handled, and (3) how family themes as personified and reflected in the adolescent's struggle for a separate identity are expressed and dealt with in the group. Corresponding issues between society and the adolescent are discussed.

ADOLESCENT GIRLS AND THEIR PARENTS: SEXUAL PROBLEMS AND PARALLELS

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This paper reports on findings about parental and family pathology in the course of long-term treatment of families in which intense concern about an adolescent girl's heterosexual behavior was a primary presenting problem. Treatment formats consisted of varying combinations of family, couple, and adolescent group therapy. In all the cases, long-term conjoint marital therapy sooner or later became a regular part of the treatment process. Although sexual problems in the marriage may have been successfully denied or minimized earlier, in this context significant sexual concerns ultimately came to the fore.

Long-term work with these families made it possible to see very clearly how parents' anxiety and conflict about their own sexuality became converted into a preoccupation with an adolescent daughter's sexual behavior. Through the operations of a family projection system, symptomatic behavior in the daughter ultimately resulted and became a stabilizing force in both marital and family equilibriums. When parents were able to shift their attention from their daughter's behavior to

their own underlying marital and sexual problems, the girl's acting-out diminished significantly.

Clinical vignettes are presented to demonstrate parallels and the interrelationship between the sexual difficulties of the girls and their parents.

METHODS OF ALTERING ROLE RELATIONSHIPS OF YOUNG SCHIZOPHRENICS

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The project described in this paper is based on the use of multiple units of families and their expatient young adult members formed into small groups to effect changes in role behavior and socialization patterns. It is conceptualized that these multiple family groups would constitute new social systems that would have greater impact for change upon each family unit.

Multiple family group counseling and shared group activities are the treatment tools utilized to alter role behavior and more effective patterns of interpersonal behavior. The multiple family units are also exposed and integrated into the life of the community center in group experiences with so-called "normal" families from the center. Evaluation results of a previous program indicated that family intervention was essential to deal effectively with two major problem areas: changes in socialization behavior were hampered by family interference and mutual interlocking patterns of family pathology in their own socialization experiences. Social role changes were also difficult to alter as the family held to its accustomed equilibrium of roles assigned to each member of the family.

The peer group is the major instrumentality for change in socialization patterns. The methodology of group counseling sessions and group socialization experiences with so-called normal young adults in the community center are the principal modalities of the program.

The methodology utilized is the formation of groups consisting of five families (parents and expatients) in each group, with group counseling and group activity sessions (art, music, folk dance) as the principal elements of the program. A self-help component is also utilized, with patient helping patient in leadership and the planning of activities to provide increased ego strength and coping skills in independent social functioning. Other tools employed are individual and group educational and vocational guidance and counseling, and crises intervention for individuals and families as critical life experiences occurred.

The major themes that emerged from the multiple family group therapy sessions are as follows:

1. The existence of a network of disturbed communication patterns displayed by the family units which clearly indicates the need for reeducation and relearning through the group process.

2. An unrealistic and inappropriate set of demands and expectations exist which creates additional barriers to the readjustment of the expatient and the family.

3. An overemphasis and concern regarding the stigma of rehospitization and the community's prejudicial response. The emotional handicap of both the parents and young adults is revealed by their discomfort with this thought of rehospitization.

4. A need on the part of parents and expatients to deal with social role performance. There is a pronounced necessity to stress different attitudes and values around family role models and social role performance on vocational and educational levels.

The current techniques of behavior modification and learning theory are being employed in experiential "here and now" counseling and activity sessions. The expatients are encouraged and helped to assume leadership roles and their parents have assumed dependency roles in certain group programs. Observation and performance of actual role behavior patterns have caused parents and young adults to reexamine and to relearn new interpersonal sets of behavior. Appropriate reinforcement and the role modeling of the workers have also effected positive changes and alterations of family role behavior and socialization patterns. It was also found that parents and expatients alike had initial, marked difficulties in becoming integrated into the community center.

One of the most frequent experiences of the group is the common bond which the participants feel. Parents and young adults feel that they can share their common problems one with the other, draw upon each others experiences, learn from the mistakes and achievements of others, and, mainly, share some of the problems outside their own family circle. The common bond was emphasized many times during the year and used to encourage participant members of the group to talk about common resources, ideas, and experiences for the benefit of each family and individual within the group.

SERVICES, STAFFING, TRAINING

THE MIRACLE OF THE LOAVES AND FISHES UPDATED: NONPROFESSIONALS FOR EVERYONE!

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The explanatory *model* which is used to account for disturbed and deviant human behavior determines the kind of *institutions* which society supports to provide intervention, and the nature of these institutions in turn determines the *kind of manpower* required for their staffing.

The explanatory model occupying the center of the stage today insists on the fiction that "mental illness is an illness like any other." It trims the stage with institutional trappings of sickness, beds, hospitals, and clinics. As a consequence, the manpower problems are defined as shortages of medical and paramedical professionals, which include the four major actors in the drama—the psychiatrist, the clinical psychologist, the psychiatric social worker, and the psychiatric nurse. The bit players include all of the ancillary paramedical professions normally found in "treatment institutions."

There is an ever-widening gap between the growing manpower needs of our tax-supported treatment institutions and the shrinking supply of professional workers. Partly this is due to an unwillingness to forego all the benefits of private practice to take underpaid jobs in public agencies serving those most in need of help. As a result there is a great deal of talk today about training a new group of nonprofessional, or semiprofessional, people to staff the places serving primarily the numerous emotionally distressed poor. As it is obvious that professional people are not interested in these low-status positions, the brilliant solution is to staff them with nonprofessionals. This third-rate idea, combined with a large dose of expert public relations, has almost convinced the public that there will soon be enough intervention to go around. Many people actually believe that a large number of housewives actually are being trained to be counselors, that hundreds of storefront intervention centers already exist, and that highly successful intervention is being accomplished at the Woodlawn Center in Chicago, at the Range Mental Health Center in Minnesota, and at Fort Logan in Denver, to pick a few places with good press coverage.

Actually, this whole show is going to fold in Boston, long before it reaches the Big Time!

There is a real need for nonprofessionals in *real* hospitals where truly sick people are treated. But inasmuch as the professionals in the mental hospitals have very little idea of what they are doing or what is to be done, it is hard to identify tasks

than can be performed with "mental patients" by nonprofessionals. As it becomes clear that long-time hospitalization is not required for most forms of behavioral deviation, even the unskilled attendants' jobs—jobs that call for simple skills such as preserving order, dispensing narcotics, instructing the professionals about what to prescribe, etc.—are declining rather than increasing in number.

What is required in this field is a whole reconceptualization of causation. Once the sickness model is replaced with a more valid social-learning explanation (which attributes most emotional disturbance to the dehumanized environment rather than to biological defect) there will follow a redefinition of intervention institutions as reeducational or rehabilitative centers which call for a very different sort of manpower.

The paper will develop the argument that this reconceptualization will lead to the establishment of centers staffed primarily by people educated at the bachelor's degree level or less, with nursing or social work as strong contenders for responsibility and leadership.

THE EVOLUTION OF MUNICIPALLY OPERATED, COMMUNITY-BASED MENTAL HEALTH SERVICES

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The locus of municipal mental health services is frequently an urban community reflecting a wide range of political, social, and ethnic complexities. The social, educational, and health needs of such a community are multitudinous; many of these needs have engendered problems which require immediate mental health intervention. It is likely that the ultimate fate and value of the community mental health movement will rest on its ability to come to grips with these complexities, and develop meaningful and relevant mental health programs in an urban setting.

Mental health programs are in various stages of development in major cities across the country, but questions remain as to the orientation, adequacy, and acceptance of these programs. A related question concerns the openness and flexibility of such programs to undergo further modification and evolution as the need arises. The development of public, community-based, mental health services in an urban area is further complicated by the fact that the urban setting differs sharply from the historic location of public mental health services, i.e., institutionally based, state hospital programs.

Experiences in developing a municipally operated, community-based, citywide mental health service in the city of Chicago are reviewed in the light of urban complexities and the historic locus of mental health services. This combination of circumstances offers strong indications that municipal mental health services must

be evolutionary at all stages of development, and that these stages of development must be empirical in their process. The evolutionary process requires close community involvement and responsibility at all levels of planning, implementation, and development. Only through such an evolutionary process can resistances to the implications of this change from professional, political, and community quarters be intelligently understood and adequately resolved.

TOWARD COMPREHENSIVE MENTAL HEALTH PLANNING: THE SAN ANTONIO EXPERIENCE

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The objective of this paper is to present the planning experience of a large urban community as it faced the task of developing comprehensive mental health services for its citizens. This case study of San Antonio has value beyond its own borders for a number of reasons.

Dominant issues such as a paucity of available services; entrenched patterns of autonomy and isolation on the part of hospitals, clinics, and agencies; the problem of long-term financing; and a generally conservative and traditional view of what constituted mental health programs—all were represented in the San Antonio situation. In addition, the population base contained a high representation of Mexican-Americans, with some census tracts having over 70% of their residents with Spanish surnames. Poverty was well entrenched in the population; unemployment and subemployment rates reached 47.4% in some of the deprived areas of San Antonio.

Given this canvas of visible need, what strategies would most immediately begin to pay off in terms of program development and service delivery? The initial strategy of delineating four catchment areas was based on the proposition that "each catchment area would have roughly equally balanced cross sections of economic groups so that neither wealth nor poverty would be concentrated in any one area." However, when we examined the four catchment areas in terms of hard resources, i.e., hospitals, outpatient facilities and the like, the distribution was found to be considerably uneven. The planning strategy had to take full cognizance of the ecology of the different catchments, with a focus on a proper resource mix which would emphasize individual catchment identity as well as shared resources across catchment boundaries. This perspective highlights what Morris has called the "underpinning array of local service delivery mechanisms into the areas where people live."

Because the "areas where people live" are not homogeneous, either in life styles or available resources, a single model for mental health service became unfeasible. The planning perspective had to deal with the whole county on the one hand, and

yet on the other hand be sensitive to the characteristics of the individual catchments. This paper describes a number of the criteria and approaches that were considered in moving in the direction of comprehensive planning and how this approach complemented the differential ecology of the four catchments.

A basic and initial consideration was the establishing of a financing mechanism that would ensure support beyond the period when Federal funds would no longer be available. In addition, local commitment was seen as a critical part of the financing situation. It was strongly felt that this responsibility should be institutionalized within the community in order that funding would become a part of the health system. This represents, as Paumelle has suggested, that the community mental health movement needs growth from below at the community level rather than from above at the Federal level only. Local financing is one such approach.

Another direction that the planning effort took was to operationalize the concept of exchange with a number of other programs in the community. In addition to this being a strategy for obtaining badly needed resources, it also allowed for a more effective and direct entry into a number of significant community levels—into organizations as well as into the population at large. Exchanges were set up with the poverty program, model cities program, a newly opened medical school, the state hospital, and other public and private health and welfare agencies. In each instance the return on the exchange was identified.

A further move that was taken was to secure representation on the various planning organizations of mental health interests. This included, for example, a regional planning body (Alamo Area Council of Governments) which was the official structure that assumed responsibility for the Statewide Comprehensive Health Planning Program. In one sense, all planning bases were covered and mental health was seen as part and parcel of the total health fabric.

Local financing and control, maximization of local resources through exchange, and involvement in other local and regional planning efforts are all seen as critical in moving toward developing comprehensive mental health programs. Further, the emergence of different models based on local ecology is sure to produce fresh insights into the definition and delivery of mental health care.

CHILD SERVICES IN THE COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER

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The comprehensive community mental health center concept has been vulnerable to criticism because of underattention to the needs of children. This is a justified criticism, and it is patently true that many comprehensive community mental health centers have not developed adequate services for children and adolescents.

The paper describes the development of child services in the comprehensive community mental health program of the City and County of Denver. Program innovations include the following:

1. Decentralization of outpatient services into service areas.
2. The elaboration of generic mental health teams as the entry point into the system for all ages and categories of patients.
3. The supplementation of generic mental health teams with a speciality consultation in the area of child psychiatry.
4. The development of backup resources for specialized child psychiatric problems, such as those of minimal brain damage, behavior of deviant children in Head Start programs, and those with major psychiatric illnesses.
5. The development of consultation services to schools and other child serving agencies.

The authors will attempt to demonstrate that it is possible to reconcile the aspiration and methods of child psychiatry, as a subspeciality within psychiatry, with those of the comprehensive community mental health practitioner. A system is described which is flexible, economical, and capable of serving the needs of large numbers of service applicants.

Unresolved problems and deficiencies in the system will also be discussed in the presentation.

THE SOCIAL WORK CONTRIBUTION TO THE COMMUNITY MENTAL HEALTH CENTER: THE DEVELOPMENT OF A NEW SOCIAL UTILITY

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In reality, the role of social work and the development of social work practice in the community mental health center are determined by the processes of creativity and conflict. These, in turn, are generated by the complex interaction of such factors as ideology, leadership, and power. The members of the various mental health disciplines differ individually and by training regarding the nature of mental illness in our society, the interpretation of the mandating legislation, the mission of the par-

ticular mental health center, the needs of the community and its right to participation in policy-making, the areas of competence of the participating professions and of the nonprofessional. Although the outcome of these processes is not predictable, the social work profession has the responsibility to develop its view of the community mental health center and the role its practitioners can and are competent to assume in its operation.

In urban settings, in particular, the face of mental illness is most frequently that of social dysfunction: an inability to navigate the environment successfully. That environment is dominated by the institutional-bureaucratic matrix through which virtually all human services are distributed. The community mental health center is in itself an institution within which the client must learn to function. Social work has been the profession which has developed, over the years, a recognition of the organization, the agency, as the means of providing services.

One priority, then, stands out in program determination. It is the responsibility of the community mental health center to help individuals and families effectively utilize an environment of large-scale organizations. Overcoming powerlessness in relation to organizations must be a major task of the center, one that needs to be directed toward those already ill and those in danger of becoming ill. The complementary task needs to be directed toward the organizations themselves, to make them more human in the administration of their services.

The community mental health center must be prepared to support the advocacy role of the social worker and move the use of advocacy from an individual effort to an institutional effort: The center itself must become the advocate.

Thus the role of the social worker vis-a-vis the organizations of the community, including the mental health center, is as important as his relationship to clients. Since most of the services in our cities are publicly sponsored or supported, the social worker involved in needed social change is involved in a political process. Accountability to the residents of the catchment area for the performance of high standard services according to community established needs and priorities is implied in the mandating legislation. Since prevention is an essential aspect of the entire program, the mandate for social change through community organization techniques must be implemented if the center is to fulfill its task.

The delivery of a full range of services of high quality, including programs aimed at changing the network of community services, requires a highly sophisticated form of social administration seldom found in today's welfare agencies. Established structures to perform as policy dictates are rarely seen. The uneasy partnership between medicine and social work contributes to poor delivery systems, since social work rarely utilizes its knowledge and skill to carry out its professional mandate.

Social work competence, whatever the worker's primary method (casework, group work, community organization), lies in the ability to understand and then effect changes in people's relationships to each other and to their social institutions. Assessment regarding the effectiveness of organizational programs and the adequacy of resources are crucial aspects of psychosocial diagnosis. The ability to function professionally once a plan for help and change has been completed requires that the

appropriate organizational tools, programs, and resources be available. Unless social work sees itself as responsible for these there will be little opportunity to mount meaningful community-based programs for prevention of mental illness and inadequate realization of the intended treatment programs of the center.

The social worker, therefore, whether as worker or as administrator, must be willing to engage in struggle and conflict to assert the full range of his competence. He must be willing to utilize political means for changing the center and engaging in change in the community. Finally, he must take full responsibility for real professional competence rather than the ancillary role of the past.

SOCIAL WORK EDUCATION FOR COMMUNITY MENTAL HEALTH CENTERS

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Some concepts and principles which community mental health professionals are rediscovering—to begin where the patient or the community is; to move at the patient's or community's rate; that lack of involvement of groups and individuals in what might affect their destiny can wreck the best laid program; the importance of including the family in treatment; building upon ego strengths; "reaching the unreached"—all these are old social work concepts translated into new public health language. Unfortunately, social workers have not played as important a role in the development of community mental health centers as these credentials would suggest because of a preference for a traditional kind of therapy on the part of caseworkers, some lack of interest in the clinical on the part of group workers until relatively recently, and a concern with the more tangible issues of bread and jobs and housing on the part of community organizers. These predelections of the practitioner, resulting in trained incapacity for community mental health center functioning, have largely been fostered by schools of social work.

The community mental health center not only requires greater involvement of the community and an increased emphasis on primary prevention but also skills in working with groups who have been traditionally underserved—the poor, the very sick, members of disadvantaged ethnic minorities, the socially deviant—and an approach which is parsimonious in the use of resources, particularly human ones. For adequate functioning within the center, a student needs to be prepared, if not to acquire competence in all methods, at least to recognize the appropriate mode of

intervention in a particular problem even if it is a method in which he is not most skilled. He needs to see beyond the immediate situation to a more ultimate cause, but must not neglect secondary or tertiary prevention (early diagnosis, treatment, and rehabilitation) for primary prevention.

To prepare social workers to function in this manner, modifications are needed in basic classroom curriculum—in the human behavior and the social environment, the social policy, the methods sequences—as well as in field work practice. A systems approach needs to be stressed throughout the program. Some innovations include a classroom course in integrated method and a multimethod field work placement. Since social workers who can teach such a multidimensional approach are scarce, the schools need to place a special emphasis on the development of faculty for both classroom and field.

THE GHETTO COMMUNITY IN TRANSITION: IMPLICATIONS FOR CLINICAL SERVICES

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The ghetto community has recently moved through the civil rights movement, the war on poverty, and the black rebellion to a position of challenging the usefulness to its people of the institutions of larger society. This challenge makes it imperative for all agencies in the community to be aware of their position in relation to various segments of the community, and to appraise the nature of their activities and attitudes in order to usefully survive.

While recognizing the necessity of a wide variety of innovative approaches to delivery of mental health services, not only in ghetto communities but in society at large, the authors are concerned about the prevalent tendency to assume traditional services and familiar theoretical principles of evaluation and treatment are useless. Our experiences as clinicians working in a ghetto have convinced us there is need for retention of hard-won knowledge and experience.

Our experience has been that members of the lower-class ghetto community seek and make good use of treatment competence. Just as the community seeks the services of architects, businessmen, etc. in their areas of specific competence, it seeks that of mental health personnel in theirs.

During the six years of our practice in a ghetto community, there have been several shifts in what the community generally finds acceptable in the practice of mental health personnel:

1. A shift away from acceptance of direction from middle-class white professionals.
2. An increased insistence on demonstrated professional competence.

3. An increased demand that competent service be made readily available to the community and delivered in a manner the community can find acceptable.

While there is a tendency in the professional community to see rejection of their services by lower-class people, our impression is this represents a demand for services that are found useful. Our experience confirms that inaccessibility to treatment is often a response to failure of the therapist. New psychiatric residents and social work students, previously well-trained in treatment techniques, in our setting often find themselves rendered incompetent until attitudinal changes (shifts in values and capacity to tolerate challenges to cherished values) occur. When appropriate shifts do occur, it becomes possible to develop appreciation of the strengths and weaknesses of life styles in a lower-class culture as the community itself perceives these strengths and weaknesses. We find such awareness indispensable to those treating the lower-class population.

While our practice can be subsumed under the concept of ego supportive therapy, we have found it necessary to emphasize specific aspects of this, notably self-actualization. The diagnosis of character disorder—the most common diagnosis of our population—often provides an excuse to take a directive role and not confine treatment to issues directly relevant to the growth of the individual. Our experience has been that individuals either refuse treatment or regress within treatment unless treatment is directed toward self-actualization.

PROVIDING MENTAL HEALTH SERVICES TO A LOW SOCIOECONOMIC BLACK COMMUNITY WITHOUT REQUIRING THAT PEOPLE PERCEIVE THEMSELVES AS PATIENTS: AN ECOLOGICAL SYSTEMS APPROACH TO A COMMUNITY GROUP

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This paper describes an approach to community mental health services to children which utilizes a natural peer group or "social network" as a focal point for bringing about change in the way in which individuals relate to their environment. The approach stimulates greater competence and more successful mastery of environment by increasing the capacity of the group members to negotiate successfully with other individuals, groups, and institutions in their ecological system. The medium is a task-oriented group approach which provides experience and structure for encounter with other institutions and subsystems in the community. The mental health professional becomes a significant part of the members' social network; he is available when crises arise in the lives of individual members or their families.

The techniques used represent an integration of the author's knowledge of community (particularly that community served by the Rebound project in South Philadelphia), group, and individual processes as well as skills developed in experience

in social group work, individual casework, activity and discussion group therapy, and family therapy.

Work with two groups is discussed: the Noble teens, a peer group of 14-17-year-old boys, and the RB Club, a partial social network composed primarily of mothers who are related through friendship, kinship, or neighborhood ties. Rationale for the choice of these two groups in terms of their significance in the ecology of neighborhood children is offered. The initial phases of both groups as they involved the core group members and the mental health professional in negotiating shared goals and mutually acceptable roles is discussed. Particular attention is paid to the role of the worker in helping the group negotiate changes. From positive encounter with the "outside world," resulting in change, those involved in the process are helped to achieve a more positive identity. The worker stands in the interface between the institution and the group. The RB Club's attempt at negotiation of an extension and improvement of a summer playstreet program is used as an example. The Noble teens' encounter with a child psychiatrist, in which they verbalized their needs and points of view in order to help him write a speech focused on bringing about change in youth-serving institutions, is also used.

Examples also illustrate the way in which the author from his unique position in the group members' social network can intervene in times of individual or family crises by touching other members of the network as well as being in touch with resources outside the individuals' current system.

The paper describes an approach to the delivery of services to children in a community mental health setting which uses the natural, or social, network group as a unit of treatment in such a way that people are not required to perceive themselves as patients. This approach has met with apparent success. It is hoped that this model can be further tested and expanded by other interveners in other settings. If the approach can show itself to have validity, it may be applicable to health and welfare institutions outside the community mental health field.

THE FATHERLESS FAMILIES IN THE NEGRO GHETTO AND IMPLICATIONS FOR IMPROVED HEALTH FACILITIES

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As a psychiatric nurse, living and working in Harlem, I am deeply concerned about the social, economic, and health problems confronting many of the fatherless families in that community. Haryou Act conducted a study in 1964 which showed that in Central Harlem alone at least a third of the youth under 18 years of age live in fatherless homes. The necessity for massive support in the area of family life within the community can flow from this observation alone.

The total family is generally accepted as the crucial area in which basic beliefs,

growth, development, and socialization are instituted. Because of this fact, I view the fatherless family in the Negro ghetto as having a long range effect on the future of the American Negro as a whole.

In order to understand more clearly the emergence of this matriarchal Negro culture, we should review certain historical events. According to Franklin Frazier, "Never before in history has a people been so completely stripped of their social heritage as the Negroes who were brought to America as slaves." In the environment of the new world, the mother was head of the family. When emancipation came, many Negro mothers had to depend upon their own efforts for the support of themselves and their children. From that time to the present day, each generation of women, following in the footsteps of their mothers, has borne a large share of the support of the younger generation.

I collected the material for this paper from the many books and articles written by authorities on this subject. The suggestions for improved health facilities came from some reading materials but also from my own personal involvement as a nurse at Harlem Hospital Center and from my role as a member of the community.

The health problems faced by the fatherless families are enormous. Almost without exception these families live in the poorest housing areas and the children attend schools which in most cases have little sensitivity to their unique problems. They also have many problems involving the Welfare Department and other social agencies. Most of these families are surrounded by others in similar predicaments; therefore, the same lack of knowledge, misconceptions about illness, and lack of motivation to do something about their conditions are transmitted from family to family.

I regard the biggest problem that exists in this cultural subgroup as the lack of a coordinating health agency that can meet the health needs of these family units by the delivery of health services. The neighborhood health centers utilizing indigenous nonprofessionals in active roles may be the answer. The organization of such centers staffed by people who are cognizant of and sensitive to the health problems of this group will be an expensive proposition. The survival of the entire Negro population in deprived areas of the nation may depend on our ability to alleviate the health and social problems of the fatherless families.

THE NORTHERN NEW ENGLAND STUDENT HEALTH PROJECT

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The Northern New England Student Health Project (NNESHP) was conceived by graduate students in the health professions as a constructive effort to transform our beliefs into action. The basic tenet of our philosophy was that the individual, rich or poor, deserved, by the virtue of his being human, excellent health care. We believed

also that the community, rich or poor, deserved, by the virtue of its composition of humans, excellent accessible health services.

The major objectives of the project were to give students a concrete experience that would increase their understanding of poverty and the current model of health care delivery and at the same time to make a positive contribution to the needs of the poor in the community. Our approach was multidisciplinary. Our orientation was to direct encounters in poverty settings with reference to health and medical problems and to the general social and economic problems of poverty.

The winter months of 1967-1968 were spent in site development. We went to the people in the poverty communities to learn what they saw as their needs and to explore the possibility of useful summer projects in each community. A student area coordinator was designated for each community not only to coordinate the site development but also to serve as a resource person for the students in the summer. A preceptor was chosen for each project, a person familiar with the community's needs and interested in advising and guiding students in their summer projects.

During the summer of 1968 the NNESHP, funded by the Social and Rehabilitation Services of the Department of Health, Education and Welfare, sponsored 31 projects throughout metropolitan Boston and northern New England. The projects were of three major types: survey, service, and community organization. In any direct delivery of medical or health services, the student was supervised by a professional. The projects were set up to allow a balance between a structured, defined situation and a flexible experience for the student to make a constructive contribution to the community and to himself. The multidisciplinary approach and the emphasis on personal contact and personal relationships encouraged the students' flexible response to the problems they saw.

A most important commitment of the projects was that they would continue year-round. During the summer, 65 students were involved; currently there are well over 125.

There are many theoretical implications of our experience. One is the question of the rationality of current organization of health services—the same resources now available could give more patients better care under different patterns of organization. Another is the notion that the absence of strong local community bonds and the resulting structured instability of social relations in contemporary society are responsible for social pathology—current approaches leave a question as to what are the causes and what the symptoms. Another is the problem of community and stability of human relations—a community should allow the assurance of stable social relations, for a consequence of structured instability is the superficial and exploitative character of transient interpersonal relations.

Our learning experience was invaluable. And we learned very quickly that our efforts must be directed not only to the poverty communities but also to institutional patterns which maintain the current status quo.

A COLLEGE STUDENT CENTER: A NEW CONCEPT IN COMMUNITY PSYCHIATRY

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Explosions of discontent among university students around the world reflect the increasing difficulties students are having in dealing with such problems as the development of autonomy and the establishment of an identity during their transition from adolescence to young adulthood. The increasing frequency and violence of their outcries suggests that sufficient progress is not being made and that more resources must be tapped and more innovative methods developed for understanding and ameliorating their problems.

The Roosevelt Hospital Student Center has been established in the past year as a contribution to this effort. It is a division of the Roosevelt Hospital Department of Psychiatry, staffed by psychiatrists and clinical psychologists. Its purpose is to provide a broad range of mental health services to the college community in the New York City area.

The establishment of the student center is part of the latest phase in the evolution of college psychiatry from the days when a university had a single consulting psychiatrist. In the present period, modern community mental health principles are utilized widely. The most recent innovation has been the pooling of the limited resources of multiple colleges in order to establish a single mental health center which serves all of them.

The student center is such a facility. We offer all of the generally accepted treatment modalities except psychoanalysis. This means that colleges whose counseling or health services are overburdened can refer students to us for low-cost psychotherapy of whatever type of duration is appropriate, from the briefest kind of treatment with very limited goals to long-term insight psychotherapy. Our emphasis is on flexibility and responsiveness to the needs of each student.

The philosophy of the student center is that it is a highly specialized portion of the general community mental health movement, our community being the college community in the New York area, consisting of college students, faculty, and administrative staff members. To augment psychotherapeutic functions, we are developing a broad spectrum of techniques which will encompass many of the principles of modern community psychiatry. We are undertaking to conduct a group process experience with a number of students. We have as a goal the establishment of a liaison function with colleges whereby student center personnel will become intimately acquainted with students, faculty, and administration, and with their problems. Our big advantage is that we are not administratively or emotionally allied with any of these factions and can therefore be viewed as relatively unbiased and impartial. From this vantage point, we can suggest and put into operation measures which are preventive as well as therapeutic.

Innovations always encounter resistance from people who are firmly embedded in tradition, and the student center is no exception to this rule. We have been wel-

comed as a center which can be available for the treatment of students who cannot find adequate treatment elsewhere. But we are encountering resistance to our becoming more closely allied with the colleges. Our plan is to respond to the needs of our community as they perceive them, and to strive ultimately toward a broad preventive, as well as therapeutic, approach.

EFFECTIVENESS OF EARLY IDENTIFICATION AS PREVENTION

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Concepts of prevention suggest that early identification and treatment are important and beneficial at critical stages in the development life of the individual. We have devised a method of identification of students in need of corrective, ameliorative, and preventive aid at the time of first registration at the university. This paper deals with some aspects of our student mental health screening program.

Freshman students are at a particularly critical stage in their development. In a certain proportion of this population an acute emotional crisis may become manifest. The student is making the big, and perhaps definitive, step of breaking away from family domination and control. When handled effectively, individuals in these crises respond rapidly to treatment, and the beneficial treatment effects may have considerable carryover for future situations. We hypothesized that we could develop a self-administered inventory type instrument that would effectively select those students who are in need of help and that our contact with them at an early stage in their college experience would be a significant preventive device which would have a positive impact upon their academic functioning.

All new students received a Student Health Information Form at the time they were sent permits to register. This form contained demographic data, medical history, and attitudinal mental health items, and was returned to the health service before classes began. Responses to the health questionnaire were visually scanned and computer analyzed. Cutoff scores were separately derived for the medical and mental health questions. In the fall of 1966, 1967, and 1968, we also administered to students with high mental health cutoff scores the Personal Opinion Inventory. This was an attitudinal-type personality inventory consisting of 10 scales: suicide preoccupation, depression, manifest anxiety, aggression, anomie, social distance, authoritarianism, personality rigidity, dependency, and attitudinal immaturity. Each of the students in the study was interviewed by a member of the mental health staff. The interviewer made ratings of the students' mental health and recommended therapy when indicated. The same procedures were applied to random samples of new students.

Complete data from Fall 1966 are available on 22 screened new students with high mental health impairment cutoff scores and 69 students from the random sample of newly admitted students. The total number of new students in Fall 1966

was 4,222. In 1967, of a total of 3,500 new students, we have data on 87 screened high cutoff group subjects and 61 random sample students. In 1968, of a total of 4,100 new students, 250 high cutoff score students and 75 random sample new students were studied.

Identifying those in need of help: seven of the 10 POI scales significantly differentiated the screened high cutoff group from the random group of new students: suicide preoccupation, manifest anxiety, depression, anomie, aggression, and attitudinal immaturity. The first three scales also correlated significantly with interviewers' recommendations for need of psychotherapy. In our combined 1966 and 1967 high cutoff screened group, 51% were offered such help by the interviewing mental health worker and the majority, 56%, of these students accepted the offer. In 1968, using a revised version of the mental health questionnaire, two independent psychiatrists found 49% of the high cutoff score groups students ($N=82$) in need of psychotherapy while our mental health staff using a previously defined rating scale method found 41% in need of help. This compares with 18% in the random sample group judged in need of help without any knowledge of the student's mental health questionnaire findings.

Our results indicate that this is a useful and workable method of early identification of mental health problems.

UNIQUE ASPECTS OF A UNION POPULATION'S INFLUENCE ON SERVICE DELIVERY

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A union-sponsored psychiatric service reports in this paper on program developments that are an outgrowth of experiences with families of workers in the food and related industries. The unique aspects of this community's characteristics have been brought into focus by the union members seeking mental health services. Common problems and areas of professional concern have emerged. The purpose of the paper is to explore and to describe some of this special population's family life problems as these relate to their mental health needs.

Empirical evidence has grown out of working with almost 18% of the eligible population. Over the eight-year period during which psychiatric benefits have been made available, repetitive patterns have been noted. Service delivery has been influenced by clinical findings with respect to life styles, and maladaptive devices. Sensitivity to this population's psychosocial needs has made for definite changes in program offered. This interaction is the source of the authors' statement.

The industry is an employer of considerable magnitude within which, in return for high pay and job security for minimal skills, constant pressures are placed on workers. Described are the characteristic industry systems which seem to have particular relevance. The problems exhibited by families who seek help are influenced by these factors. Of note are the limited "in presence" opportunities for relating and interacting that results from the shifting work schedules, as well as from the frequency of parents working different schedules. The sequelae are often multi-problem families and maladaptive patterns.

A broad mental health concept has influenced the development of services. Often unconventional usage has been encouraged, such as the clinic's serving as a "family doctor" or a substitute nurturing parent. Efforts are directed at meeting the problems by offering diverse modalities as well as traditional psychotherapy. Services are designed to meet problems of early childhood, range through the needs of adolescents in crisis and of troubled adults, through the concerns of the retired pensioned senior citizen, the upheaval presented by psychoses and hospitalization, and other life crises. Staff and administration make continuing attempts to identify "clusters" within the population for whom specific programs can be developed in such a way as to best utilize community psychiatry concepts.

INITIAL INTERVIEWS: A COMPARISON OF TRADE UNION MEMBERS AND PSYCHOANALYTIC CLINIC APPLICANTS

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The objective of this study was to learn about the dimensions that characterize the way in which patients from a blue collar population and applicants for psychotherapy and psychoanalysis at the William Alanson White Institute Clinic present themselves in initial interviews. We sought to define the distinguishing characteristics of each group and then make comparisons, hoping by this to sharpen our perceptions of the therapeutic situation with both groups and thus increase our clinical effectiveness, especially with blue collar patients.

The study was based on a total of 12 initial interviews. Six were interviews with blue collar workers done in connection with the Union Therapy Project of the William Alanson White Institute. This project offers treatment to United Auto Workers' members as part of the health and welfare benefits program of the union. These six interviews were selected at random from those done between November 1965 and April 1966. The clinic applicants were selected to make a group roughly comparable in chronological age to the union patients. All patients had been seen by the same interviewer, all patients are male.

After the sample had been selected, each case was reviewed in turn. The authors discussed in detail what had been written regarding the initial interview and what the interviewer could recall that would round out the picture available from the

interview summary. In the discussion special focus was placed on every aspect that seemed unique about a particular patient and on all the similarities between patients in a particular group.

Five areas were found where issues differentiating the groups could be articulated: (1) attitude toward seeking help, (2) style of self-presentation, (3) relationship to self and history, (4) attitudes toward work, and (5) attitudes toward sex and sexual activity. In general, union patients saw treatment as a way to get justification for their behavior and feelings. Problems were often seen as arising from circumstance rather than inner sources. Introspecting and articulating inner experience were more familiar to the clinic patient than to the union patient. In the union patient, words were deemphasized; action was what counted.

In all instances but one, at initial interview the union patient ignored past experience as a significant source of present difficulty. One might speculate that the ubiquity of trauma and tragedy in the lower socioeconomic class lead to a social climate in which tragedy is not novel, a marked contrast with the middle-class sense of outrage and injustice at the "raw deal" one is getting if things do not conform with middle-class expectations.

MODELS OF OUTPATIENT PSYCHIATRIC PRACTICE

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Outpatient practice has developed along four major models. Each can be viewed as representing a form of response to the body of information that exists about psychiatric disorders, patients who are prone to them, contexts in which they arise, and mechanisms of intervention. In this paper the four organizational models are detailed and compared for similarities and differences. Comparative analysis of the models also elucidates the structural aspects of clinic organization which are loose and encourage diversity, and those which are fixed and tend to remain stable.

The dynamics underlying the developments of these different organizational models in psychiatry are presented. A phase of model variability, i.e., a period during which different models of psychiatric practice are adopted—spin-offs, is described. This phase is distinguished from a still later phase in the modeling of organizational practices in psychiatry: model generalizability. In this latter phase, attempts are made to adapt all the clinical models to fields other than outpatient psychiatry, as schools, detention centers, geriatric facilities, community centers.

Analysis of organizational developments that have taken place in outpatient psychiatry is useful in showing how shifts in aims and goals affect practice, and how, in turn, prevailing practices influence goals. Such analysis also points out the degree of certainty that exists in the various areas of psychiatric knowledge, for the ways we tend to implement our philosophy and provide structures for operating are clues

to the kinds of data in which ambiguities and insufficient information persist and the areas of data in which we have already found closure.

PSYCHOSOCIAL FUNCTION AND STAFF DECENTRALIZATION ON AN INPATIENT WARD

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The removal of staff in one ward of a hospital from departmental line authority offers interesting problems. This approach was adopted at a large drug addiction treatment center because certain aspects of the behavior of drug addicts undergoing detoxification are difficult to handle by traditional approaches. Within a short-term treatment setting (14-24 days), it is difficult to deal with the problems produced by the patient's constant attempts to evoke differential responses from various staff members.

To minimize manipulation, each patient is assigned to a staff person who handles practically all his needs from the time the patient arrives on the floor until he is discharged. Such concentration of patient-staff interaction calls for the establishment of generic function and the diffusion of traditional staff roles. Individual members of the staff are no longer recognizable by their activities as counselors, nurses, social workers, occupational or recreational therapists, but simply as generic staff. The worker assigned to each patient fulfills all the functions previously provided by various disciplines except those limited by law, e.g., the giving of medication by nurses. Diffusion of function is accompanied by enhanced responsibility and more effective interaction. To further implement the concept of decentralization, administrative responsibility for the ward and supervision of the staff is assigned to the psychiatrist in charge of the ward rather than to departmental staffs.

Supervision and inservice training by the psychiatrist are feasible when the degree of psychological sophistication is recognized. The traditional difficulties of young and inexperienced staff (projection of magical powers upon the psychiatrist, anxiety about their own inability to solve patient problems quickly) occur but can be dealt with under these circumstances. The use of T-groups has been found to be effective in encouraging staff interaction and reducing staff anxiety.

In addition to administrative decentralization, structural changes are necessary to support these new job patterns. Separate nursing stations, social service, and counseling offices have been replaced with a common staff office with desks for each member. To reduce long intensive one-to-one therapy sessions, desks are placed close together in the staff office. To encourage patient-staff interaction, the staff office is open to the floor and freely accessible to patients.

Patient records have been revised. Charting is done mainly by the staff member assigned to the patient. Records formerly kept by various departments have been

brought together. Staff members write their notes sequentially on the same pages of the chart rather than in sections reserved for each specialty.

Staff-patient interaction has increased markedly under this program. Interdisciplinary quarrels have not been observed among staff members who see themselves more as members of the same ward staff than of different departments.

This type of decentralization raises new questions concerning recruitment, salary differences, promotion, and career lines for the staff and their relation to traditional hospital hierarchies. The implications for student placements and specialty training are of considerable import.

The impact of such decentralization upon the results of patient care will require a rigorous clinical trial. On the other hand, the impact upon the unit staff is positive and provides an opportunity to study the feasibility and consequences of ward decentralization within a hospital structure.

ATTITUDES TOWARD FOSTER FAMILY CARE IN CONTRASTED SOCIOECONOMIC COMMUNITIES

Joseph L. Taylor and Dorothy Kipnis

Association for Jewish Children, Philadelphia, Pennsylvania

Jerome L. Singer and John Antrobus

City College, City University of New York, New York

A Likert-type scale in questionnaire form, pretested and encompassing eight facets of foster family care, was administered to 808 subjects from different communities in which the Association for Jewish Children and the Philadelphia Department of Public Welfare recruit foster family homes. The data was analyzed by carrying out separate as well as joint factor analyses of responses.

Negroes in the DPW sample expressed great interest in becoming foster parents but seemed blocked on following through because of suspiciousness, bitterness, and resentment toward the community and the established agencies which administer foster family care programs. Although the Negro area selected for study is not a disenfranchised, severely alienated ghetto neighborhood, nor one characterized by summer riots or hard-core unemployment, the strong sense of alienation and bitterness is, nevertheless, evident. The AJC respondents, residents of well-established neighborhoods and socially unthreatened, reflect positive attitudes toward the community and the agency. They see the value of foster care and are sensitive to the psychological needs of foster children, but they express only slight interest in becoming foster parents. The DPW population sees foster family care more in its physical than psychological aspects, realistically understands that much of foster family care is permanent, and realistically assess other aspects of the service, such as its practical difficulties. AJC respondents hold more sentimental views and believe foster care is largely temporary.

Though the white subjects in the DPW sample differ from the white in the AJC community, these differences are much weaker than contrasts between Negroes and whites. Respondents with grown children are least interested in foster care, families with the most children (five or more) are most consistent with the general pattern of the DPW sample (more interested in foster parenthood), and in families where there are fewer children the data resembles the characteristics of the AJC sample (less interested). The younger respondents are more receptive to foster care, are more knowledgeable about its processes, less embittered, and more oriented towards the needs of children. Occupationally, the greatest interest in foster care emerges among women who are clerks or domestics and whose husbands are in semiskilled or service occupations. Women with husbands in professional, managerial, or sales occupations show a general pattern most closely resembling the total AJC pattern.

Communities may need to consider developing self-help or intermediary structures within the Negro community to overcome resistances that act to keep interest in foster parenthood latent or dormant. The outlook for recruiting Jewish foster family homes is not encouraging. This research suggests that by presurveying the information level and attitudes of a community, some understanding can be acquired of the particular views or resistances that would need to be confronted in recruitment campaigns.

SOCIAL STATUS AND CHILD PSYCHIATRIC PRACTICE: THE INFLUENCE OF THE CLINICIAN'S SOCIOECONOMIC ORIGIN

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This report, one of a series emerging from a long range investigation of social class factors in child psychiatry, reaches into a critical, relatively unexplored area of investigation, namely the proposal that mental health professionals should be recruited increasingly from socially disadvantaged groups. The proposal has been challenged by some who hypothesize that such professionals would express insecurity about their new status by alienation from patients and clients of their class of origin.

Method: In an effort to evaluate the merits on each side of this argument, we collected data about social characteristics of the parents of the child psychiatrists on the staff of the University of Michigan Children's Psychiatric Hospital. Following this, we studied whether the apparent social biases in clinical perception described in our previous studies obtained equally for those clinicians whose socioeconomic position had remained consistent over their lifetime as compared to those clinicians who were upwardly mobile. Study of the background data on the clinicians placed many of them in one of two groups: (U) those who had lived in upper middle class surroundings their entire lives; (L) those whose upper middle class status

was achieved concurrent with the acquisition of their professional qualifications—their formative years having been spent in a lower socioeconomic environment. These two groups were homogeneous in terms of professional experience and the age and social status of patients they evaluated.

Findings: Despite the internal consistency in the two samples, the clinical observations and recommendations made by the different groups of clinicians demonstrated significant discrepancies: (1) Of the 228 youngsters evaluated by the clinicians in group U, the diagnosis of chronic brain syndrome was employed 11 times whereas the clinicians in group L used this diagnosis only once in the course of evaluating 228 patients. (2) Group L evaluators diagnosed neurosis significantly less frequently in lower-class children than in any of the other social strata and significantly less frequently than group U clinicians diagnosed neurosis. (3) The psychiatrists in group L recommended the more intimate psychotherapies significantly less frequently for lower-class children than did the group U clinicians.

Comment: These and a variety of other findings are detailed and discussed in the complete report stressing the educational and training implications inherent in recruiting helping professionals from disadvantaged backgrounds.

PROFESSIONAL NURSE EDUCATION IN THE CONTEMPORARY SCENE

Gean M. Mathwig

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This paper presents the attempt by one program of nurse education to identify and fulfill the responsibilities involved in educating the modern professional nurse. Three major areas of responsibilities were identified and served as the frame of reference for action: (1) the professional nurse educator as a member of higher education, (2) the professional nurse educator as a member of professional education, and (3) the professional nurse as an individual citizen.

Responsibilities of the professional nurse educator as a member of higher education were identified as the criteria of higher education and the responsibilities inherent in the academic community. Similarly responsibilities as a member of professional education included the criteria of professional education and the ethical, moral, and social responsibilities of the nursing profession to the consumer public and to potential students. Responsibilities as an individual citizen included, in turn, the socioeconomic factors of equality of educational opportunities and the promotion of conditions and facilities for deprived groups conducive to enrollment and success in school and in the profession.

The approach to fulfilling these responsibilities included coordination of the nurse education activities with the overall university plans for recruitment, enrollment, prerequisite remedial courses, college preparatory courses in the School of Continuing Education, and tutorial services. Likewise included was a straight-

forward presentation to potential students, interested groups, and organizations of the types of nurse education that prepare the graduate for the specific nursing career chosen.

The approach also assumed an active role in promoting conditions and facilities for deprived groups conducive to success in school, and upgrading education and on-the-job potentials. Active participation and planning with college-bound and high school counselors, meeting with members of the black press and black organizations, and establishing additional scholarships and funds for the financially deprived were all part of the program.

The focus has remained a straightforward approach relative to the responsibilities of professional nurse education to society, in this our contemporary scene. Otherwise stated, the focus has been, not what can the contemporary scene contribute to "my" profession and enrollment in "our" nurse education program, but rather what can "my" profession and "our" nurse education program contribute to the community. Integrity and sincerity have remained mandatory prerequisites. The program has been and continues to be increasing in number of activities offered, students enrolled, and academic-community participants. Thus the program per se has been and continues to be the gratifying factor.

RELEVANCE OF PROGRAMS IN OTHER LANDS FOR EMOTIONALLY DISTURBED YOUTH

Henry P. David

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To add an international perspective to the report of the Joint Commission on Mental Health of Children, a systematic survey of current trends was conducted in more than 40 countries. Focus was on the organization and delivery of services in other lands and their relevance for evolving practices in the United States.

In most countries child mental health services are an integral part of, or closely affiliated with, child health and welfare programs. These are usually perceived as more of a public than private or voluntary responsibility. Expenditure of tax monies for children's services is widely accepted, generally in addition to programs sponsored by private sick benefit insurance funds. In many developed lands, a broader and more integrated range of services is more readily available to all socio-economic strata of the population. Greater responsibilities and status are accorded child care staff having limited formal qualifications. There is less concern with program evaluation or cost effectiveness. Formal presentations of observations have a lower priority; there is less pressure to publish or convene conferences.

An American traveling abroad will usually perplex his hosts by asking about "innovations" in child mental health services. It is generally held that the best theoreticians have already migrated to the United States; that American computers can quickly determine who is doing what where with which results; and that

American concern with costs reflects an outmoded service-for-an-individual-fee concept for which Europeans, for example, long ago substituted a combination of mandatory social security and sick insurance benefits. The notion of daily costs, and separation of operational and capital budgets, is of limited concern to most professional practitioners abroad.

In sharp contrast with current U.S. practice are those social welfare oriented and/or collectivist societies which have established central planning, state directed coordination of services, and some control over manpower training and placement, coupled with a strong tradition of comprehensive social security and sick benefit insurance coverage. Examples range on a continuum from the Netherlands and the United Kingdom, through the Scandinavian and Israel, to the socialist countries of Eastern Europe. Particularly informative are the reports prepared by members of the 1968 U.S. Mission on Mental Health to the Soviet Union, citing the coordinated network of preventively-oriented, readily available, geographically accessible, and free of cost mental health services with built-in continuity of care.

There is no claim that colleagues in other lands have made dramatic breakthroughs in developing innovating services. It is entirely conceivable that nearly every program reported from abroad can be found somewhere in the United States. What does impress most American visitors is a divergence in attitude, a seemingly greater flexibility, a willingness to experiment with differing approaches to programing and delivery of services, and to be creative in administrative and therapeutic roles.

Direct comparisons are elusive. There are differing approaches in diverse geographic regions. Ideological differences are an important determinant of the organization, range, and quality of services provided. However, no one country, no one profession, and no one ideology has a monopoly on innovative programs in child mental health. It is time to learn from each other, from our mistakes as well as our successes.

THE FRENCH EDUCATEUR APPROACH TO THE REEDUCATION OF DISTURBED AND MALADJUSTED CHILDREN

Thomas E. Linton

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The French government has developed on a national basis a very rational and coherent approach to disturbed and maladjusted children. The approach includes a carefully articulated series of services for these children. These services include observation centers, reeducation schools, vocational training, youth hostels, and social and recreational centers located in economically depressed areas.

A major emphasis in this system is placed on careful observation and diagnosis previous to the placement of the child in an institution. The institutional placement is matched specifically with the child's strengths and deficits in an attempt to maximize his opportunity for effective reentry into the social system.

With this highly integrated and nationally concerned approach to childrens services, it became necessary to establish a new professional corps of "child care" workers to effectively staff these centers. This new professional, called an *educateur*, was developed because of the need for highly qualified individuals to work on a close personal basis with disturbed and maladjusted children. The French authorities realized that the child care worker's role was of extreme importance in the restoration of the maladjusted, disturbed and delinquent population. They saw that the future of this profession was directly related to the quality of the training provided. If the training program is highly selective and maintains a high standard of professional growth and career opportunity, the people drawn to this new career would provide for more effective reeducative models than was the case in the traditional residential treatment centers. Hence, the French government provided official recognition of this new professional role and established training centers for *educateurs* throughout the various regions of France.

The key to much of the effectiveness of the *educateurs*' work is found in their highly rationalized training process. The central components of this training are very careful initial screening of candidates, intensive integration of theoretical and practical factors in the training process, emphasis on cognitive and personal views of the trainee as these relate to child care work, individual and group sensitivity training, depth involvement in daily life of maladjusted children, and extensive skill in and use of craft, manual, athletic, and cultural activities to gain interest and participation of the young people in their charge.

Essentially the *educateur* approach to disturbed and maladjusted children is a radical departure from the patterns utilized in the United States. This approach provides a reeducation model which is directly able to answer the problem of the shortage of trained manpower in the mental health fields. There are about 500,000 disturbed children in the United States and only a very small percentage of this total are receiving any kind of meaningful assistance. The vast number of children who need assistance in the United States cannot possibly obtain help within the context of our present approach to this problem. Both in the field of education and in the traditional mental health disciplines a creative approach to mental health programing is drastically needed. The *educateur* concept of total milieu programing offers a therapeutic model which could have wide scale and effective use for the vast number of disturbed and maladjusted children in the United States. This model could also provide the means of revitalizing the currently dysfunctional teacher training process.

MENTAL HEALTH SKILL TRAINING FOR NONPROFESSIONALS: A RESPONSE TO COMMUNITY NEED, A CHALLENGE TO PROFESSIONAL TEACHING TRADITIONS

*John C. Dillingham and Sandra Sutherland
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A description of an eight-month pilot project in mental health skill training for nonprofessionals working in a wide variety of service programs in a large metropolitan area. The paper traces the growth of the project from a spontaneous voluntary training seminar of 10 nonprofessionals to a multifaceted pilot project that has trained more than 400 workers without professional mental health training or education, attracting wide community support as well as foundation and government funding.

The project provides new mental health skills for the wide range of nonprofessionals who, with the fewest opportunities for training and the fewest referral resources, encounter most immediately the broadest range community and personal mental health problems among those they serve. Emphasis of project programs is upon specific mental health skills. The philosophical and experimental basis of the emphasis is that the nonprofessional, through learning, discussion, and testing of specific mental health skills, will be able to generalize the specific skill onto a more theoretical level from which he may then identify the need for other specific skills. The result which the project is designed to produce is threefold: (1) a repertoire of skills adequate to serve representative age ranges and typical mental health problems; (2) an understanding of emotional problems and the principles of their treatment; and (3) an ability to identify from the repertoire those skills that may be successfully applied to which situations, and why.

The paper describes the experience of the founders of the project in developing a program of eight-week seminars, one-day workshops, inservice training, consultation programs of varying length specially designed for agencies or groups, and orientation sessions. Included in the training were mental health workers, recreation leaders, teachers, day care staff, corrections officers, youth workers, counselors, clergy, volunteers in health and welfare programs, public welfare workers, etc. The initial conceptions of mental health techniques of such students are noted, as well as the typical practical problems and diagnostic dilemmas they bring to the training milieu. Of particular interest is the educational interaction among students from a wide variety of job backgrounds and educational diversity.

The paper discusses the skill focus of various seminars—Work with Low-Income Unmarried Parents; Diagnostic Thinking and Planning; Children of Deprivation—and of various workshops—Crisis Intervention with Adolescents; Today's Dilemmas of Drugs, Discipline, and Delinquency. Development of rapport with the community is discussed from the procedure used to identify the training needs of over 13,000 nonprofessionals, to eliciting active support from community agencies for

staff participation, to the development of a structural relationship with a professional school of psychiatry and a community-based neighborhood settlement house.

UTILIZING NONPROFESSIONAL CASE AIDES IN THE TREATMENT OF PSYCHOTIC CHILDREN AT AN OUTPATIENT CLINIC

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Zanwil Sperber

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A central characteristic of children with severe psychopathology is their isolation from relationships. Their lack of interpersonal trust, revealed by defensive withdrawal and absence of motivation or capacity for communication, presents a barrier which must be breached before a basis for further personality growth can occur. The long-term nature of the process by which the child tentatively reaches out and tests the reliability of significant adults requires a heavy investment of therapeutic time. Must this time be provided by the highly and expensively trained professional clinician?

This paper describes a program using lay therapists to work with severely disturbed (atypical, schizophrenic) children. We assess the program's effectiveness; examine training parameters; discuss the interpersonal pressures and the compensatory group processes and satisfactions which sustain clinic staff and volunteers in the endeavor.

We have worked, to date, with one girl and five boys and their parents. The children ranged in age at the onset of treatment from 5 to 8½. The initial diagnoses were: the girl, "inadequate personality with symbiotic features perhaps of psychotic proportions"; two boys, schizophrenic reactions of childhood; one boy, an autistic childhood psychosis; one boy, showing developmental delay and schizophrenic withdrawal; one boy, possible retardation or schizophrenia. Our work with each of these children and their parents covered a minimum of six months to a period of two years.

This paper is based on observations made in the course of twice weekly one-hour therapy sessions with the children, and group therapy sessions with the parents. Two children and two therapists regularly worked together in one playroom. Other lay therapists observed, and would move in when one of the regular therapists had to be absent. Thus, within a few months the children had been in contact with more than the two regular therapists, but nevertheless seemed to spend more of their time with one of the regular therapists—a tendency which was fostered by our permitting one therapist to assume major responsibility for a particular child.

Anecdotal evidence will illustrate the positive impact of this therapeutic program on the children—it seems to help foster their emotional and ego growth. Our ob-

servations of the parents indicate they were initially focused on seeking intellectual understanding of their problems in a way which would alleviate them of guilt. But gradually they began a process of exploring deeper feelings about personal dissatisfactions and marital dissatisfactions which the earlier focus on the child had permitted them to evade. Transference manifestations towards the therapist and intense emotional involvement between the parents and each others' children have increasingly become visible. This process demonstrates the importance of parent participation if a therapeutic program is to be effective.

From the point of view of clinic organization, and enhancing the capability of an institution for dealing with a variety of problems, this program has had major heuristic payoffs. Specifically: (1) We have observed a point at which the severely disturbed child does begin to expand his horizons by relating more consistently to adults. Following this step further, programs of an educational nature, harmonious with and complementary to the psychotherapy but independently focused, are necessary if the pace of the child's growth is to be continued. We have identified gross lacks in the ordinary community and educational establishment's resources for dealing with these needs. (2) Teaching lay therapists, screened primarily in terms of warmth, interest, and ability to be comfortable in the face of gross pathological symptomatology, by rapidly immersing them as direct observers of the children and participants in the group supervision, leads to more rapid growth than previous educational programs with intellectual (course) work preceding clinic contact.

JOBS, FAMILY LIFE, AND SOCIAL CONCERNS OF THE YOUNG ADULT RETARDATE

Elizabeth M. Boggs

National Association for Retarded Children, New York, N.Y.

The current emphasis on assimilating more of the mentally retarded into "the community" requires us to consider not only how well the retarded person can be trained or counseled to "adapt" to society but also how well society can modify its institutions and its demands in order to accommodate the atypical person, particularly the less competent person.

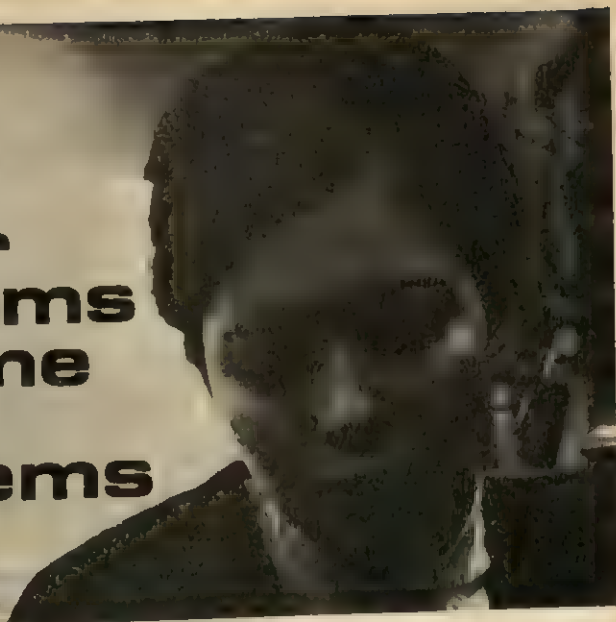
Such modification is not merely a matter of "more accepting attitudes" generated by "public education" (beginning with professional attitudes) but must extend to the planned development of modified social institutions in the major domains of work, shelter and domestic life, and leisure-time resources. Such tempering of traditional expectations must be as inconspicuous and nonstigmatizing as is consistent with a genuine response to the actual irremediable deficiencies of the retarded adult. The concepts of sheltered employment, halfway houses, hostels and sheltered boarding homes, and adapted recreation programs are addressed to this need.

It appears, however, that there is a further need for social support from capable,

perceptive individuals so that each retarded person of impaired competence can have access to an acceptable person as advisor and mediator. Such a person need not be a member of the retardate's immediate household. In his study *The Cloak of Competence* Robert Edgerton found that even among the mildly retarded persons discharged from an institution as capable of independent self-maintenance, the majority survived only with the assistance of informal "benefactors"—some of whom were benign and some authoritarian. More seriously retarded persons may find their lives molded by a "protective payee" or a "representative payee" appointed by one of the public income-maintenance social agencies.

Who can best render such services and at what point these functions should be formalized through guardianship is a moot question fraught with myths and prejudices. The underlying social issues have yet to be fully exposed and used as a basis for social planning and action.

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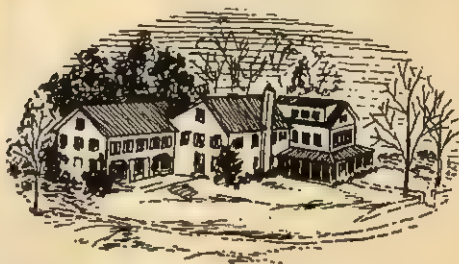
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LETTERS TO THE EDITOR

Professional Neutrality And the Drug Issue

TO THE EDITOR:

Most of my colleagues in the mental health professions will privately agree that the current widespread persecution of users of the newer drugs has a destructive and alienating effect upon our young people, far outweighing any damage from the drugs themselves. As in the case of clothing, hair length, and other manifestations of the youth culture, parents, educators, and law enforcement officials react to their own unresolved problems by striking out at the younger generation. Parents will tell me in one breath how they had to "lay down the law" about their son's clothing or hair length or had to prohibit their daughter from going out with a boy because he smoked marijuana, and in the next breath they will express bewilderment that their son or daughter does not trust them or confide in them.

Since these adults are influenced by others in sustaining their beliefs, especially by professionals trained in human relations, why is it that mental health professionals so seldom express publicly the truths that they privately acknowledge? Some of my colleagues will tell me quite candidly that we should not risk provok-

ing adverse public reaction by taking a position that challenges popular bias. Does this mean that we are to allow that minority of professionals who share the popular bias on certain issues to speak for the profession? A good example is the joint statement by the Council on Mental Health of the American Medical Association and the National Research Council which labeled marijuana as a "dangerous drug"—a statement that would not bear close scrutiny. Having decided that the drug presented psychological hazards to some users, they arbitrarily concluded that legal prohibitions should remain in force, without even considering the possible harm of such a curtailment of freedom from the psycho-social point of view.

By defaulting our responsibility to speak the truth openly in matters of professional expertise, we encourage the public to persist in misconceptions and thereby do them a grave disservice. The neutral position has its place in the professional interview, but to carry it over to the realm of controversial public issues is both illogical and irresponsible.

*Thomas S. Harper, M.D.
Asst. Clinical Professor of Psychiatry
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March 23-26, 1970

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JUDGE DAVID L. BAZELON

PRESIDENT, AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, 1969-70

At long last—and at a singularly appropriate time in its history—the American Orthopsychiatric Association has a distinguished jurist as its new president in the Honorable David L. Bazelon, Chief Judge of the United States Court of Appeals for the District of Columbia Circuit. A brief



review of past and present Ortho concerns serves to put this election in perspective.

The American Orthopsychiatric Association was founded in 1924 by nine psychiatrists "working in the fields of delinquency and criminology." Two years later, its membership was opened to psychologists, social workers, and "other professional persons whose work and interests lie in the study and treatment of conduct disorders," but it was not until 1931 that a psychologist was elected president, not until 1949 that this honor was accorded a social worker, and not until 1969 that we have elected a judge—a long odyssey when one re-

calls the concerns that activated our founders. But if that lag had to occur, it could not have ended in a year in which the wisdom brought to his office by our new president was more apposite.

We have just been through a national election in which "law and order," a slogan

generated by the radical right, was deployed effectively by the successful candidate with the device of muting its raucousness but retaining its message by adding "justice" as an afterthought. Moreover, we are in the midst of an era in which judicial opinions have a growing impact on patterns of clinical practice. Witness the recent Supreme Court decision on "chronic drunkenness," the controversy surrounding the "right to treatment," and the growing concern about the ethical implications of technological advances. What is the definition of death when a comatose person can be maintained indefinitely by cardiac and respiratory assistance

devices? Is the bearer of an XYY chromosomal anomaly responsible for his criminal behavior? Are national stores of demographic data filed by individuals of such overriding social value as to justify the risk of loss of privacy for the individual?

But, before we turn to issues and opinions, let us consider the nature of the man himself.

David's first accomplishment, a not inconsiderable one then even as now, was to grow up in Chicago and emerge successfully from its public school system. He enrolled in the Liberal Arts School and then the Law School of Northwestern University, which awarded him the B.S.L. in 1931. He was admitted to the bar of Illinois in 1932, served as Assistant U.S. Attorney for the Northern District of Illinois from 1935-40 and returned to private practice until 1946. In that year President Truman brought him to Washington by appointing him Assistant Attorney General of the United States, where he served until 1949 when the President appointed him to the United States Court of Appeals. He became Chief Judge of that Court in 1962.

But what has this to do with Ortho? With all respect to the judiciary, there are judges and there are judges. They may preside over the legal affairs of our patients (and ourselves) with greater or lesser wisdom, but what have they to do with the professed purposes of our organization as defined in its constitution: "to unite and provide a common meeting ground for those engaged in the study and treatment of problems of human behavior" and "to foster research and spread information concerning scientific work in the field of human behavior, including all forms of abnormal behavior"? However that

question might be answered for judges in general, this judge in particular has had much to do with Ortho's central purposes.

The easiest way to document this assertion is to rehearse in brief the appointments, awards, and memberships of our new president. He has been Lecturer on Psychiatry and Law at the University of Pennsylvania (1957-59), Sloan Visiting Professor at the Menninger Clinic (1960-61), Regent's Lecturer at UCLA (1964), lecturer in psychiatry at Johns Hopkins University School of Medicine (1964-), and Clinical Professor of Psychiatry (socio-legal aspects) at George Washington University (1966-). He has given the Brandeis Memorial Lecture (1960), the Isaac Ray Award Lectures of the American Psychiatric Association (1961), the Edward Douglas White Lecture at George Washington University (1964), the Lowell Institute Lecture, Harvard Medical School (1964), and the David K. Niles Memorial Lecture at the Hebrew University of Jerusalem (1966). David was elected an Honorary Fellow of the American Psychiatric Association in 1962, has been a Fellow of Ortho since 1957, and a Director 1965-68. He has also served on the Board of Directors of the Joint Commission on the Mental Health of Children, of the William Alanson White Foundation, of the Brandeis University Center for the Study of Violence, of the President's Panel on Mental Retardation, of the Salk Institute for Biological Studies, and has been a member of the National Advisory Mental Health Council of the Public Health Service.

But these multiple appointments and awards serve only as external testimony to the recognition that David Bazelon

has received for his unique contributions to legal scholarship and as measures of his active involvement in social action for the public good.

Far more to the point are his significant judicial opinions and scholarly writings that have opened and developed an entire area of law which, prior to his influence, was rarely taught in law schools or written about in legal journals, and even more rarely practiced by lawyers. In 1954, Judge Bazelon wrote the opinion in the now famous case of *Durham v. United States*, setting forth a new rule of criminal responsibility for the District of Columbia. Although that opinion was not his first judicial utterance on the relationship between law and the behavioral sciences, it was a decision which first focused the attention of the legal world on the District Court of Appeals as the court from which guidance would come in this area of central concern to psychiatrists and lawyers. In subsequent years, under the leadership of Judge Bazelon, that Court refined and altered the test of criminal responsibility. The original decision and its subsequent refinements have not met with uniform acclaim in the judiciary; indeed, many other courts have rejected the *Durham* rule. What is significant is that every court has been influenced by that decision either in modifying its former rule or at least in being forced to redefine the issues at stake. The American Psychiatric Association, in honoring him for this achievement, described it in these terms: "Through his opinion Judge Bazelon has brought to American jurisprudence the concept that when criminal acts are perpetrated as a result of mental illness, the courts will consider the nature of the illness of the accused. In this achievement he has re-

moved massive barriers to communication between the psychiatric and legal professions and opened pathways wherein together they may search for better ways of reconciling human values with social safety."

But, even before this landmark decision and certainly subsequent to it, Judge Bazelon had been concerned with the relationship between poverty, mental illness, and crime and with the paucity of facilities for exploring the issue of responsibility in depth. His Court has raised questions about the quality of the psychiatric testimony too frequently given in court, and of the quality of the treatment provided the sick when they have been incarcerated in hospitals by court order.

Indeed, in 1966, Judge Bazelon's Court ruled in substance that a person committed to a mental hospital, even following acquittal on criminal charge, has a legally enforceable right to receive "adequate" treatment and that the court must determine whether the treatment rendered is, indeed, adequate. For, without such a determination, the incarceration of the mentally ill constitutes little more than an imprecise and unspecified form of preventive detention. The Court stated: "The hospital need not show that the treatment will cure or improve the patient, but only that there is a bona fide effort to do so." This decision, like that in the case of *Durham*, has not lacked its critics. Some psychiatrists have feared the interposition of the courts in a judgment they regard as medical; some lawyers have objected to an extension of the courts' responsibility to an area conveniently overlooked in the past. But this decision has forced explicit consideration of the ethical and legal aspects of a social

practice widespread in our communities and rarely ever before given the serious thought it merits.

Judge Bazelon's legal opinions and his extensive writings in medical and legal journals have generated a new concern among legal scholars about the themes he has brought forth. Literally hundreds of law review articles and dozens of law school courses have been stimulated by his ideas. Young legal scholars at Yale, Harvard, Columbia and other law schools have begun to make significant scholarly contributions in the attempt to come to grips with the new concepts he has enunciated.

Within the fields of medicine and psychiatry, new ethical and legal issues are coming to the fore explicitly. When an individual has suffered extensive damage to the central nervous system, such that recovery of sentient function is no longer possible, what consideration should govern the behavior of physicians who are able technically to maintain the function of heart and lungs for an indefinite period and who, if the patient is to be permitted to die, must take the responsibility for disconnecting the apparatus that is maintaining a vegetative existence? Not only is this of concern to the individual family but to society as well in terms of the allocation of scarce resources. And it takes on particular salience in an era when transplantation of organs to save the life of another might be more successful if the organ is removed before "death" as traditionally defined has occurred. In another area, we must consider the impact of legislation that makes mandatory the performance of laboratory tests (such as those to identify metabolic diseases in the newborn) when such legislation may have been promulgated

prior to the time when medical evidence was convincing that the procedures have more potential for good than harm. Finally, we in Ortho who have always been concerned with confidentiality and privacy must now become involved in the public debate stimulated by the new power for data storage and retrieval generated by computer systems. To the social scientist, it is abundantly clear that a national data bank of demographic information would permit a much greater degree of precision in answering questions of importance for social policy planning. Yet, since the utility of such data requires that they be filed by the individual for cross-correlations to be made, there inevitably arises a significant risk that information that the individual might not want to have known about himself can be put into the hands of central authorities, whether they be benevolent or despotic in intent. Who, we may ask, shall guard the guardians?

Our new president has been concerned in a broad and profound way with these issues of ethics and legal responsibility. In so doing, he has maintained a humility about the social influences that act upon the judge himself as an arbiter of social values. To quote from a recent paper:

The public has a powerful urge to idealize judges as Olympian dispensers of impartial justice. And judges, whether as the authors or as the willing victims of the public myth, contribute to it. The objection to judges who deny their true role in adjudicating cases is not merely aesthetic. The problem rather is that such stratagems prevent both judges and the public from focusing on the actual questions.

I would never criticize the courage or the wisdom of the Supreme Court justices who declared in 1954 that public school segregation is unconstitutional. The conclusions of social

scientists that "separate" facilities, however "equal" in tangible factors, engender feelings of inferiority in Negroes was relevant to that decision. But by relying so heavily on these findings, the court may have misstated the true basis for *Brown v. Board of Education* and in so doing may have misled the public. In 1896 the Court had approved the "separate but equal" doctrine. While the country might then have lacked the sophisticated studies available in 1954, any honest person would have conceded at the time of *Plessy v. Ferguson* that segregation undoubtedly would have made Negroes feel inferior. The assumption of inferiority was the rationale for the practice; no black man could help but perceive that separate train cars and separate schools kept him in his place.

Since we already knew what Kenneth Clark and others told us, the public could justly ask of the Supreme Court in 1954 why the law had changed. The answer, of course, was that our values had changed. *Plessy v. Ferguson* was discarded not because social scientists told us that segregation contributed to feelings of inferiority, but because by 1954 enough people in this country believed what

they did not in 1896—that to thus insult and emasculate black people was wrong, and intolerable, and therefore a denial of the equal protection of the law to blacks.

This brief essay has perhaps given a picture of the breadth of Judge Bazelon's contribution. It remains only to add that his warmth, his sense of humor, and his passionate commitment to social betterment make him a colleague and a friend whom we have been proud to know and who it is a pleasure now to salute as our incoming President. If these are troubled times for our nation and for our professions, our Association could not have its governance in firmer hands. If we will but give to David Bazelon a measure of support in proportion to his own massive contributions, the American Orthopsychiatric Association can become a major force for social good.

Leon Eisenberg, M.D.
Editor

OPINION

Youth in Transition

The theme topic for this year's annual Ortho meeting was, appropriately enough, Youth in Transition. Quite obviously, because of their growing numbers, their increasing education, their affluence, and their effective intercommunication, our youth are becoming a significant new force affecting the nature of society. Already to a considerable degree there has developed around us a complex intermediate culture with its own publications, its own styles, its own political organizations, its own leaders and heroes and enemies, with its own visions and its own hierarchy of urgencies.

How to facilitate and adapt to this growing influence is a major problem of our times. The human enterprise would

probably best be served—both from the standpoint of the development of youth and of its continuing contribution—if there were neither too strong resistance nor too ready capitulation to their press for change. As with every other major force affecting society today—like improved communication that extends our social contacts while diminishing our privacy, like those industries which add to our creature comforts while polluting the environment in which we live, like the police who constitute a protecting force to one segment of society and an intimidating force to another—the contributions of youth will undoubtedly be, in their own vernacular, a “mixed bag.”

It is interesting to ponder the thought that the conditions which gave rise to a large middle class in America—a group who were to be counted upon to ensure political and cultural stability—those very conditions were also instrumental in creating a new social phenomenon, a youth in position to exert unparalleled influence for change on society. Our technology and economic condition make it both possible and necessary to keep youth out of the labor market, make it both possible and necessary to keep

EDITOR'S NOTE: Opinions are invited by the Editor from members of the Editorial Board and of the Board of Directors and from other Fellows of the Association. Each represents the viewpoint of its writer on a controversial issue in the field. Responses from readers to these opinions will be published in the Letters to the Editor column.

youth occupied with learning longer than ever before in history. Freed of the responsibility to ensure their own survival and security, and free to explore their own social, emotional, and intellectual development throughout the entire first two decades of life, the youth of the middle class may very well be exhibiting wholly new potentials in the development of man. Once the dread ancient threats to survival, security, and salvation are attenuated, the young begin to discover for themselves, and for us, the growing inadequacies of our political and social and educational and religious institutions. An affluent youth is not necessarily a contented youth, and as historic urgencies are relieved wholly new ones arise to take their place, for in society as in science there are few final solutions and each new advance uncovers entirely new problems and opens up entirely new vistas in man's slow but steady evolution.

One aspect of this surge of change should have particular meaning for the

"mental health" professions, for the social scientists, for educators, for the clergy. Individually and collectively, man seems to be striving toward some optimal mode of interaction between self and society. His own crude understanding of the phenomenon of self is matched by the crudity of the institutions and systems he invents. Increased self-understanding may gradually teach us to make fewer unreasonable demands on our environment, on the one hand, and on the other to gradually modify or eliminate those institutions that do violence to man's internal harmony. For creating a better world in which to live is merely the complement of coming to understand better how to live in the world around us. We in Ortho have a special responsibility to learn from some youth and to teach others as best we can these dual necessities of social evolution.

*William F. Soskin, Ph.D.
Editorial Board*

Confrontation or Cop-Out?

Not so long ago there was a time when social protests were safely muffled and practitioners, professors, and scientists enjoyed the comfortable and undisturbed life. Conflicts there were, some of them professional, like the comparative merits of competing personality theories or therapeutic practices. And not infrequently some were social conflicts, but even these we could contend with comfortably in the solitude of our office or, with more heat and ex-

citement, at our meetings by means of a theoretical analysis of the problem or a resolution calling for the government to change its behavior.

Now many have been wrenched from this state of relative detachment and, willingly or not, have been confronted with social conflicts in daily professional life. There is no longer time to wait for an annual or even a monthly meeting; resolutions don't help nor do analyses, even the most profound, that are not

immediately convertible to operational decisions. The dean, principal, or agency director must decide *now* on the posture to take in response to demands submitted by spokesmen who may at this moment be awaiting his decision. Those in positions of authority or influence are compelled to make decisions that are unavoidably controversial.

For all who lead and have influence (which means all professionals), it is profitable to examine the kinds of responses that are likely to exacerbate rather than resolve conflict, to frustrate rather than midwife change, to stimulate rage and violence rather than trust and responsibility. Each such response is a flight from confrontation, an avoidance of the necessary dialogue, or, in a word, a cop-out.

Laymen (or students) are not competent to make decisions about professional (or academic) matters.

One can find evidence that seems to back this up, like the controversy and violence connected with the Ocean Hill-Brownsville experimental school district in New York. But searching analysis generally reveals that the failure in such cases is not of the community's making but due to ill-considered planning on the part of ambivalent top-level leaders. After years of neglect, the poor planning almost suggests that failure was built-in.

Personal experience with a student advisory committee and with student participation in a combined faculty-student senate has shown me that the student perspective adds a necessary dimension and contributes to the wisdom of the group's intelligence. Experience with a community group, consisting of some adults who had not gone beyond eighth grade, was even more of a liberal

education. Community representatives came forth with a plan not essentially different from and as good as any that professors or school people would have created, but what is more, it was their creation and it was they who were to profit from it.

The greatest obstacles to effective working together are in the pride and stereotypes of the professionals; once these are dealt with, students and laymen are seen to need experience, encouragement, and a warm welcome to enable them to make contributions that are unique—unique because their perspectives are different.

The demands of social protestors should not be taken at face value because their motivations are unconscious.

This response too has at least some grains of truth because every organization and every mob attracts some whose personal motivations, conscious or otherwise, are quite independent of and sometimes antagonistic to the group's. To indict a group's behavior because allegedly it is innervated by unconscious drive is to lead to absurdities.

Lewis Feuer, a sociologist, writes that student movements though altruistic are "pulled toward extreme and amoral means because the driving energy comes from unconscious sources."¹ Writing about the Berkeley movement in particular he refers to the moral surrender of the elder generation and the dethronement of the superego: "A psychological parricide had taken place on a massive social scale; the fathers were in debacle, defeat, de-authorized, floundering; the fathers confessed that their values were wrong, but only under the physical compulsion of the sons. Freud once described the guilt which followed a primal

parricide. Here the parricide was psychological, and compounded by the elders' own abdication."²

The consequences of Berkeley according to Feuer? Drugs, public sexuality, the lowering of the country's public ethics, the election of Governor Reagan. Associated, yes, but only simplistic thinking could lead to the conclusion that any of these, even the election, was a "consequence" unrelated to issues that were rending the nation.

In the same issue of *Change in Higher Education* in which Feuer gave his views, Henry Mayer said that the hostile reaction to student actions is elicited not by the form they take, for these are quite acceptable if these actions follow a football victory (e.g. disruption of traffic), but by the ends that are sought. Some of the very people who condemned student action at Berkeley and Columbia applauded it in Czechoslovakia. Most Americans, Mayer said, are not yet prepared to commit themselves to the stands that the students have taken. Hence the hostility. Student activists, he says, are not the troublemakers. "They are responding as outraged human beings to all the brutalizing and irrational conditions that disfigure and trouble this country and diminish the quality of our common human life."⁴

The use of the unconscious as an explanatory principle in social-historical movements could lead to the following absurdities: The French Revolution with all its good aims deteriorated to violence because the childhood experiences of Robespierre et al. created a reservoir of repressed sadistic impulses which suddenly erupted with orgiastic fury. Our forefathers accepted the enslavement of blacks and wrote it into the Constitution as a displacement of anger and humilia-

tion at being subjected to control by the mother country.

The attribution of the unconscious to those arguing for change only beclouds the issues and is more likely to lead to frustration, outrage, and violence.

The issue is not whether the students are unconsciously driven to parricide but rather whether Mayer's estimate of their goals is valid or not. If they are, student behavior is easily explained by a careful reading of history—American or any other—which shows that social gains are initiated, if not largely won, by pressure and power not by gentle petition.

The scholar, scientist, and professional must maintain his detachment from secular demands if he is to protect his integrity.

This response to social conflict, a sophisticated rationalization for escape, is not easily dismissed, because the objectivity required in our work does necessitate a certain degree of detachment whether we are engaged in laboratory or field research, in diagnosis or treatment, in social service or residential care. This old problem has anguished many a physical scientist, especially since the second World War.

The philosopher Northrop Frye has made this analysis: "The scholarly virtue of detachment, we said, is a moral virtue and not merely an intellectual one: what is intellectual about it is its context. It turns into the vice of indifference as soon as its context becomes social instead of intellectual. . . . Detachment becomes indifference when the scholar ceases to think of himself as participating in the life of society, and of his scholarship as possessing a social context."³

The uses made of all scholarship and all science, including behavioral science, are social and are a matter of concern. There is no escaping the moral implications of a professional group's decision as to the allocation of its resources. What it studies and whom it serves are social concerns, a fact that is apparent when glaring and monstrous examples are used, as in the study of the comparative merit of different types of human skin for the manufacture of lamp shades. Such a study involving multiple variables calls for sophisticated design. The moral problem is more subtle but no less real when questions arise about the use of short-supplied researchers or practitioners to increase industrial profit rather than serve the needs of the slum dweller.

Just as vocal groups are now challenging the hoary practices of the schools and universities, and exerting grassroots power to influence foreign policy, they are likely in the coming decade to do this in connection with all professional services. So at least is the prediction of three social scientists⁶ in their study of social problems of the future who contend that authenticity will be the hallmark of professionalism in the coming decade.

Social and behavioral scientists are equipped to study social problems but not to introduce action programs for their resolution. They should stay in their studies and laboratories, emerge for purposes of observation and data-gathering, and return to the campus.

Charges like these have been made against those social scientists in the foundations and universities who have given leadership in the formulation of structures for school decentralization.

In his recent book, *Maximum Feasible Misunderstanding*, Daniel P. Moynihan, now President Nixon's adviser, makes the most systematic attack on social scientists and social work leaders for the gross errors (implied in the book's title) in their community action theory. Social scientists, in effect he says, should stick to their own affairs and stay out of action programs. Their involvement, he writes, led to the intensification of social conflict and hence to the backlash and the Wallace movement of this past election year. Instead of community action, what was necessary was ". . . a fixed full-employment program, a measure of income maintenance. . . ." ⁷ Adam Wolinsky reviewing Moynihan's book points out what Moynihan surely knows: that the community action program costs far less than a massive public works program whose cost neither the Kennedy nor Johnson administration was willing to support.⁸

If social scientists are to be faulted, it is not for involvement but for their support of patently inadequate programs that were doomed to fail to win "the war on poverty." Toy guns don't win wars.

A recent Harvard faculty report entitled "The University and the City" questions the frequency with which the intellectual knowledge of the disciplines is relevant to the judgments vital to the direction of public policy. "Even the best social scientists rarely answer, expertly, a question put to them by a public official; typically they tell the public official that he is asking the wrong question." ⁹ But if a question is wrong, then is not posing the right question an important contribution to social action?

The solution for professionals and behavioral scientists is not withdrawal

from broad social policy-making, even though withdrawal can be safer because attacks on established power or ways of life always elicit counterattacks; the solution is in more forthright positions, especially if we really are honest in our concern about primary prevention.

There is one major occupational hazard that obstructs even the best-intentioned in this endeavor—an excess of “scientism.” In our best tradition we seek evidence, carefully sifted objective evidence, from reliable and valid sources as a basis for testing hypotheses. Data of that type on many of the important questions about people-involvement, school decentralization, the prevention of alienation in all its many forms, are simply not available, but that is no reason for timid responses. History itself suggests some of the answers, and these are supplemented by theories and some hard data in the social and behavioral sciences. Now that we have “rediscovered” that even in this affluent society there is hunger and starvation, it does not require a controlled experiment to permit us to assert without violating the canons of science that the correction of poverty will have a salutary effect on mental health and intelligence, nor need we be hesitant to predict on the basis of historical precedents that this “war on starvation” will be opposed as vigorously as the food-stamp program and the war on poverty.

One way to characterize the stage of development of a profession is by the

extent to which it seeks to anticipate the future. As stated earlier, some social scientists predict that laymen will be involved in establishing policy and evaluating services in the coming years. Even those professionals who respond unwillingly to change ought to make a virtue of necessity and bring to bear in our developing professions the acumen of those who have been recipients of services and probably will be participants in shaping the services in the not too distant future. Chances are, only then is our society likely to begin winning these “good” wars—victories which are indistinguishable from primary prevention.

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Milton Schwebel, Ph.D.
Editorial Board

Communication from American Orthopsychiatric Association to Joint Commission on the Mental Health of Children

Early in 1968 the American Orthopsychiatric Association presented to the Joint Commission on the Mental Health of Children a statement* of its hopes that the Commission would not follow the ineffective path of the White House Conferences on Children and Youth of the past six decades. In that statement we pointed out what seemed to us the reasons for the enormous gap between the promise of those excellent conferences and their accomplishments. Since then the Joint Commission's Task Forces I and VI have delivered their preliminary reports and the OSTI† study prepared for the Commission has been completed. These documents have now been studied by the AOA Liaison Committee, and once again we feel that we must speak out, must try to bring our influence to bear on the basic issues to be reflected in the final Joint Com-

mission Report. We cannot offer less than a clear and firm statement of our principles and the open, resolute commitment that we, as an organization of professionals and citizens intensely involved in the health of children, will act accordingly.

The preliminary reports' documentation of the physical and mental health status of children in the United States, of the results of poverty, racism, neglect, disparity, disorganization and fragmentation of services is overwhelming. They describe nothing less than the progressive impairment of the hearts, minds, and bodies of the poor—black and white, brown and red. It therefore comes as a shock to find, despite hints of the need for fundamental social change and the reallocation of priorities, that some projections in the reports appear to be based on the assumption that we will

This communication was sent to the Joint Commission by the AOA Liaison Committee to the Joint Commission on the Mental Health of Children.

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† Organization for Social and Technical Innovations, Cambridge, Mass.

continue to have the same type of racially prejudiced, poverty-stricken, unplanned, chaotic society in the future. The National Advisory Commission on Civil Disorders has indicated that such a society cannot exist much longer in its present condition and that it must change. It is the direction of change with which we are concerned. The social, economic, political, psychological, military, and moral considerations involved are so imperative in their immediate implications that we must face them squarely, offer our solutions, and devote ourselves to their resolution. Otherwise, no amount of tinkering with the quality and patterning of services will have any significant effect on the lives of the country's children.

Our statement to the Joint Commission last year gave only some traces of the underlying problems we believe it must deal with. For instance we said nothing about housing. Civilized housing is so important to the mental health of children that the Joint Commission should probably spell out the specific number of millions of housing units that need to be constructed in this country. Although Congress has recently approved additional construction, the amount is inadequate to the need and once again the most impoverished receive short shrift.

We said nothing about employment—the right of each individual to participate in society in a way that maximizes human dignity, a society where human needs and values are not determined or allocated by productivity or the profit considerations of the market place. Job training, sheltered and protected working circumstances for our poor and dis-

abled, and the facilities and expertise to implement them must receive our highest priorities.

We almost totally neglected rural areas, in our concentration on the problems of the cities. The tremendous pressure of events and power struggles within metropolitan areas may explain our concentration, but in many respects the difficulties in the cities—hunger, illness, education, housing, unemployment, and other constituents of the plague of poverty—are aggravated and much more severe in rural areas, particularly in the South and Appalachia. The problems of children and families living in rural poverty are so overwhelming that we tend to avoid the urgency of their call for our attention.

More immediate to our professional concerns, we said that "integration of personnel and facilities may eventually call for a National Health Service as the only efficient fashion of distributing care adequately." Medicare and Medicaid have served only to make it more apparent that one of the most feasible solutions is a National Health Service. Too many reports, including those of the Joint Commission itself, have documented the deficient, inequitable, fragmented, discontinuous, nonpreventive, inhumane, grossly inefficient health services provided the poor. Even the middle and upper classes do not escape inadequacies of medical care. The failure of the national government to provide direction in the reallocation of resources has been explicitly stated by Robert Q. Marston,* director of the National Institutes of Health. He acknowledges the inequities of care distribution but fails to address himself to the central issue.

* Robert Q. Marston, 1968. "To Meet the Nation's Health Needs." *New England Journal of Medicine*, 279 (10): 524.

"The Federal role in health services," he says, "is not direction but stimulation." The private sector, however, as is overwhelmingly evident, has not succeeded. The recent revelations of the large profits accruing to pharmaceutical companies, with inordinately high drug costs to the consumer, amply demonstrate that we cannot rely upon the voluntary cooperation of the medical-industrial complex. Health insurance as a means of payment without a change in the basic structure, particularly the fee-for-service basis, has already demonstrated its inherent inability to solve the problems of the quality and distribution of care. It merely tends to perpetuate deficiencies and to invest the economically interested with greater strength to resist change. We should not have to repeat painful historical experiments which inform us that in an area so vital as health we cannot afford to permit the market place to determine the nature and distribution of services.

In our limited discussion of education, we omitted some vital aspects of the needed reorganization and restructuring of the educational system. We stated that "educators must be included in all planning for children in the community" but said nothing of the necessity for parents to be involved as representatives of their children and their community. And we said nothing of involving the students themselves from their earliest years and with increasing roles as they mature. Community participation, as a matter of fact, must be applied to every social institution referred to throughout the Joint Commission reports.

We warned about dangers inherent in the medical-industrial complex but did not include the same warning about the

growing activities of the educational-industrial complex. The recent combinations of electronic companies with giant publishing houses to market expensive automated teaching devices does not augur well for the educational consumer. Largely untested, these devices have, where tested, not shown themselves to be superior to ordinary teaching or to vastly cheaper programed booklet teaching—they are merely far more expensive. The companies involved have already stated explicitly that it is not their responsibility to demonstrate efficacy and efficiency, it is the buyer's. This doctrine of *caveat emptor* cannot be accepted in considerations of health and education in our complex technological society. Just as we have passed laws protecting the consumer against untested, inefficacious drugs, we must do the same for the vital area of education. Indeed, we cannot halt there: the quality and safety of food, shelter, clothing cannot be left to the conscience of the supplier; nor can the consumer be left to the mercy of the seller as to the cost and distribution of these necessities.

Having discussed medical-industrial and educational-industrial complexes, perhaps we should return to the source of those terms and restudy that prophetic document, President Eisenhower's farewell address to the American people on the dangers of the military-industrial complex. The conjunction of an immense military establishment and a large arms industry has the potential for a disastrous rise of misplaced power, Eisenhower warned. "The total influence—economic, political, even spiritual—is felt in every city, every state house, every office of the Federal government. . . . Our toil, resources and livelihood are all involved; so is the very structure

of our society." Disarmament, he pleaded, is imperative. But the eight years intervening since that plea have seen an 8% increase in the military personnel establishment and an even greater increase in expenditures for hardware. It is these that have contributed to the cuts in aid for children and mothers, in education, health, other social services. National Science Foundation cuts are scheduled to reach 20-25%, those of the National Institutes of Health 15-20%. We cannot have war without cutting mental health services; we cannot have war except at the expense of life.

It would appear quite proper for the AOA Liaison Committee to raise at this point the matter of racism in American society and to take a position based on the Report of the National Commission on Civil Disorders, which states that we are a racist society and that we are drifting into a country of two separate groups based upon race. This committee wishes to make it crystal clear that it considers apartheid, whether in South Africa or in the United States, a symptom of a fatal social illness and one which requires rapid and, if necessary, desperate remedies. We are so conscious of the grosser forms of racism and discrimination that we lose sight of the more subtle and institutionalized forms pervasive in our professional activities in the area of child mental health and even in the classical sociological, psychological, and psychiatric doctrines.

It is relatively simple to look back and recognize the inherent racist thinking that went into the removal of Indian children from their families to place them in schools and white families. The Bureau of Indian Affairs, with white

middle-class values, may have considered this the only way they could inculcate a different and "higher" level of values and living standards. The Bureau evidently did not believe it possible to raise the standard of living for the Indian family to enable the Indian child to secure education and health care and cultural values at home, thus preventing the establishment and continuation of Indian reservations. What this did to the Indian child and his parents in terms of lifelong unhappiness, we now know.

But the finer racist distinctions in thinking are more difficult to confront. They exist on all levels of government, from Federal through state to local, in welfare, health, and education departments. We are fully cognizant of what slavery did to the Negro family, but when we look at the same maternal dominance and male inferiority and rootlessness in modern urban minority-group life, we tend to forget that this was forced upon poverty-stricken black families by chronic male unemployment and subemployment and by our welfare rules which would not support a family with an employable male available.

Some theorists then go on to attach to the poor the concepts that they are not future-time oriented and have no capacity, as do the middle classes, to delay gratifications, ignoring all the evidence to the contrary—the capacity, for instance, of the migrant Mexican-American farm laborer to exist throughout an entire year on the pittance earned during seasonal labor, spreading expenditures thinly and carefully. We also ignore evidence of the seeking of immediate gratification in the middle classes, their heavy mortgages and installment purchases.

Some sociologists speak, with almost

no comparative data, of the lack of concern and loss of love of ghetto mothers for their children, forgetting their hard and frustrating life conditions and ignoring the separation of parents and children in upper-class homes with nurses, governesses, boarding schools, and all the paraphernalia of changing and disintegrating urban and suburban family structure.

As child mental health professionals we have long been appalled by the relationship between wholesale deprivation and discrimination and the broad gamut of organic and psychological problems at every stage of a person's development. We know that failure to have fundamental needs met from the very earliest stages of infancy through adolescence may result in a range of crippling effects; that trust in others can fail to develop properly, leading to difficulties in relating to others; that the ability of the adult to be productive, to enjoy work, to gain gratification from close relationship with others, to deal with adversity, can be impaired. There is no doubt that there are higher rates of organic insult to the brain attributable to deprivation of maternal nutrition, inadequate health care, exposure to stress, poor schooling, and the full range of factors involved in poverty and discrimination. But the evidence at this time tends to indicate that Negro rates of psychoses are no higher than whites, that the reason minority groups are hospitalized more frequently is because of social pressures, inability of families to care for disabled members, or the indifference and neglect by society to furnish adequate care in the community. Nevertheless many mental health workers continue to speak of the

poor as impulse-ridden, helpless victims of distorted inner drives.

Middle-class white professionals became aware of the nature of these false assumptions when minority group members began to participate in our activities, when they began to have a share in control over statements and programs concerning them. We have learned much about them in the last decade as we have worked together in civil rights movements and on local boards. They are as capable and perhaps more willing to learn from the professionals as the professionals from them. This equal and dynamic participation in learning and decision-making is the beginning of the accountability of professional workers to the community. It is this mutual accountability which must be built into the structure of our social institutions and the services they offer; into the school systems, the health care agencies, the very fabric of our society. These social institutions do not belong to or exist for the professional or any other worker or owner but belong to and must serve the community. It is this simple lesson which is so difficult to learn and which is causing so much difficulty at this time.

And the accountability must go much further. True experimental evaluation of all aspects of service programs must be provided for and the findings fed back in order to change them for the better. This becomes particularly important at a time when new and innovative methods for presumably equitable and efficacious care are being advocated and offered.

The previous AOA statement said nothing about our obligations to the poor throughout the world, whose desperation will help push us over the brink if our self-interests alone are con-

sulted. What can we say in the face of the stark fact that the United States contribution to the poverty-ridden countries continues to fall instead of rising? An answer that the contribution ranks us at least somewhat higher internationally than does our maternal and infant mortality rate does not reflect to our credit. What can we reply to those countries which beg for food for their starving millions? That we must maintain our economy of scarcity by withdrawing millions of acres from production, paying millions of dollars to those needing it least, and driving millions off the land into the disintegrating cities? The report of the Joint Commission should indicate specifically, we feel, what our increasing commitment to the world's poor should be in terms of food, technicians, technology, the wherewithal for population and famine control—for what happens to children in other parts of the world will ultimately affect the lives of America's children.

We closed our previous statement with the somewhat vague comment that "Ultimately the programs discussed above can be achieved only by a basic reallocation of our resources in terms of personnel, industrial production, and funds to meet human needs in our changing society." This can and must be made more specific. The report of Task Force VI informs us "that a larger proportion of the total antipoverty tax burden is borne by those earning less than \$4,000 than by any other income group" and "that the poor (the bottom 20% of families)" receive only 5% of the national income yet they pay an average of 30% of direct taxes of all kinds. In contrast, "90% of American millionaires pay no income taxes at all." Not only is it apparent that the poor do

not receive their fair share of tax benefits but it is equally apparent where a sizable resource for services to children exists and should be tapped.

However, the nature and extent of the problems we have uncovered and the programs we have in mind require much more than can be derived from plugging tax loopholes and taxing the inequitably taxed rich. The money for the jobs, housing, education, health care, and other ingredients of a dignified existence can come only from those tremendous resources now allocated to destruction. We must as citizens commit our society to the dismantling of our destructive and nonproductive war machines and industries. We must ask it to withdraw from Vietnam as the first step, both as a moral and constructive end. We must indeed end all hot and cold wars and commit ourselves to noninterference with the social and governmental structures of all other countries as well as to the cessation of any military aid to any country. We realize that achieving priority for truly human aspirations in a vastly multipurposed society such as ours will be extremely difficult and that we exist on a planet with other countries whose actions are frequently conditioned by our actions. But we are unquestionably the most powerful and the richest; it is our obligation to take the first steps; we cannot expect the weaker to begin. We must commit ourselves to nuclear disarmament, to the reduction of our armed forces by a fixed ratio, to response to similar moves by other powers. Only in this fashion can we secure the manpower, the housing, the food, and the clothing necessary to fulfill our commitments to children and the future.

THEORY AND REVIEW

CHILD PSYCHIATRY: THE PAST QUARTER CENTURY

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Historiography is a constant dialogue between past and present; it takes new form from the grounds of the shifting present. The historian 25 years hence will almost certainly view our recent past from perspectives quite different from our own, having at his command new viewpoints and more distance from the controversies in which we are still engaged. We can only hope he will be kind to those of us then still alive, and show due respect for our venerability if not for our perspicacity. I beg him to forgive me for limiting my survey mostly to this continent, but this is the only scene I know well enough to dare these comments.

Fortunately, our assessment of recent developments can take as its starting point the insightful and balanced comments of Professor Kanner, who, in a series of scholarly and delightfully literate publications,³²⁻³⁵ has attended the birth and early childhood of child psychiatry. The paternity of this hybrid in-

vites us to invoke the mechanism of superfecundation, involving as it did general psychiatry, the juvenile court movement, defectology, education, child development, psychoanalysis, pediatrics, and child guidance. Although textbooks concerned with the "mental diseases" and "insanity" of children had appeared before the turn of the century, they were primarily exercises in the imposition of adult nosology upon childhood disorders.³⁴ It was not until 1926 that Homburger³⁴ wrote the first treatise on the psychopathology of childhood that can be said to be informed by a concern for the child as a person, and it was not until 1935 that Kanner³⁶ published the first American textbook with the title *Child Psychiatry*. By the 1930's child guidance clinics were a burgeoning feature of the North American scene. Tramer's *Zeitschrift für Kinderpsychiatrie* had been founded, and Heuyer had organized an international congress in Paris under the title "Psychiatrie infantile."

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The year that marks the opening of our survey (1943), appropriately enough, was the year in which Professor Kanner³⁷ reported the previously undescribed syndrome that has come to be known as early infantile autism, the first instance of a psychotic disorder peculiar to childhood. To that point in time, the contributions of child psychiatry might be summarized in these terms: The desirability of multidisciplinary study of the child in his family had been well established. At an operational level this was reflected in the collaboration of the social worker, the psychologist, and the psychiatrist in the child guidance clinic and in the eligibility of all three groups for membership in the American Orthopsychiatric Association.^{44, 57, 65} The first effective drugs, the amphetamines, had been introduced.⁶ The thesis that adult disorders have antecedents in childhood experience had been broadly accepted; true, this idea had been introduced into psychiatry by Freud without the benefit of child study four decades earlier, but the accumulating clinical reports of child psychiatrists had given it—or at least appeared to have given it—empirical support.

The enthusiasm for prevention, again a doctrine enunciated at the turn of the century in the mental hygiene movement, now became the province of children's clinics. In much the same spirit that Victor Hugo had proclaimed that the opening of each new school meant the closing of a prison, the community was led to expect that each new child clinic made obsolete an adult mental hospital. However distant the day of its realization might seem, given the shortages of funding and manpower then as now, there was no lack of conviction that the control of mental illness could

be attained by a proper network of child guidance clinics, training of school teachers, and education of parents. And this conviction was no mere matter of naive optimism on the part of our professional forebears; the nature of their daily clinical work with its high rates of symptomatic improvement in the children they cared for appeared to verify their beliefs.

Yet for all the honor due to child psychiatry for having pioneered a broader view of patient-family-community interaction than was then typical of adult psychiatry, our horizons were constricted by our focus on the clinical study of the individual patients and families who passed through our clinic doors. It is only in the last decade that we have begun to recognize that population studies are essential^{62, 68} and that clinic intake has unintended as well as deliberate bias built into it.¹ Once appropriate controls for social class were introduced, it became difficult to verify the widespread assumption that such variables as age and method of weaning, toilet training practices, sex education, or the parental attitudes measured by standard inventories distinguish clinic patients from other children.⁴⁸ Such factors do indeed vary significantly by social class but they fail to predict patienthood. In contrast to such factors, what did discriminate patients from controls in a study⁴⁸ of a sample of our clinic population was the experience of separation from parents by illness, death, or desertion and the occurrence of marital distress.

Many of the formulations which seemed to have explanatory value when applied in retrospect to patient populations that were skewed in unknown fashion by gate-keeping procedures dis-

appeared into insignificance when appropriate sampling and control techniques were introduced.

Such errors, in my estimation, have stemmed in part from the isolation of the child guidance clinic from medicine, on the one hand, and from child development on the other. No physiologist would describe a normal heart in terms derived solely from the study of a failing one; had he done so, Starling would have concluded that ventricular output decreases rather than increases in relation to ventricular dilatation. Yet we have generalized from our clinical work with troubled families to theories of normal development. Freud's experience before the turn of the century should have warned us of the unreliability of our patients' reconstructions of their past; what he first thought to be historical events he later discovered to be fantasy. Yet he and we have persevered in our preoccupation with those fantasies in lieu of the more laborious task of accumulating detailed prospective accounts of the vicissitudes of development. It has been only in the last decade that systematic longitudinal studies by such careful workers as Professor Chess⁷⁰ and her collaborators have begun to supply the information necessary for a meaningful account of the interaction between temperamental characteristics, parental behaviors, and social experiences in generating personality traits.

It is therefore not surprising that the promissory note of prevention issued by the mental hygienists has not been able to be redeemed.¹⁶ If theories of cause rested on such uncertain foundations, nonspecific interventions are not likely to have been highly productive. Indeed our decisions on the "suitability" of particular children for treatment seemed to

have been based more on our class biases than on the patients' psychiatric needs.^{68, 71}

The Furman et al.⁶⁷ study of voluntary psychiatric facilities, facilities supported by charitable as well as tax funds, identified preferential service to those health areas that were better off economically. The most recent survey,⁴⁹ carried out by the New York Council on Child Psychiatry under the sponsorship of the Joint Commission on the Mental Health of Children, decried the long waiting periods for screening, prolonged intake procedures, clinic hours inappropriate for working parents, and other factors which summed to produce high dropout rates and differential likelihoods for treatment such that the least ill and the least poor families (within clinic income ceilings) were those most likely to be treated psychotherapeutically.

On the other hand, the most significant long-term followup study⁵⁹ ever carried out in our specialty has documented the lamentable outcome of just those children least preferred by clinic intake policy, the antisocial, the aggressive, the disorganized. As Professor Robins and her co-workers have shown, the neurotic child, though still at higher risk for psychiatric illness in adulthood than classroom controls, has the best prognosis for favorable outcome even in the absence of care. Yet just such children are, or at least have been, preferentially sought by therapists. Mind you, this is no injunction to sprinkle psychotherapy on delinquents; there is little evidence that they benefit therefrom.⁵⁵ It is a call to concentrate our efforts on developing methods of care for those disorders that constitute the major threats to public health.¹⁷

To its credit, the past decade has seen

the first systematic studies of the outcome of psychotherapy for children. In general, the findings have not been reassuring.⁴¹⁻⁴³ Although occasional studies, such as one my associates and I carried out,¹⁸ do provide some evidence in favor of psychotherapy, most studies have been unable to provide systematic evidence of benefit when the treated are contrasted with waiting list or designated controls. This point requires clarification. Not to have found a difference is not equivalent to having demonstrated that there was *in fact* no difference. Measures of outcome employed in most studies are admittedly crude; significant differences in attitude and in values, which may stand a child and his parents in good stead for the future, may emerge from sensitive and skilled psychotherapy and not be reflected in symptom counts, given the evanescence of symptoms in children.⁴⁰ But the counterassertion that change *has* been produced requires documentation. It is yet to be forthcoming.

What is remarkable is how little effect these studies with their Scots verdict of "not proven" have had on professional practice. Surely, at the least, they should have lead to major investment of energy and effort in studies to define the indications for, the best methods of, and the limitations to psychotherapy rather than what can only be compared to a religious conviction in the possession of an exclusive road to salvation. And for all the interest aroused by the newer forms of psychological treatment such as family therapy^{3, 4} and behavior therapy,²³ there has been just the same dearth of controlled studies and the same evangelical proselytizing by the newly converted. Let me make it clear if I can: I regard both of these innovations as substantial contributions. I plead only

for the necessity of controlled evaluation of their efficacy. I urge only that we abandon the Doctrine of Panacea and instead begin with the more likely proposition that particular methods will best suit particular patients and that the obligation of the psychiatrist is to be competent with a variety of treatment methods from which he can choose the one best suited for the individual patient.

All too often, what has been the liberation of one generation becomes the bondage of the next. If we can fairly claim credit for the introduction of the team of psychologist, social worker, and psychiatrist, we are also guilty of having elevated it to what Kanner has termed "the holy trinity." Countless extra hours go into "interdisciplinary communication" in situations where one qualified professional could more effectively manage the problem without ending up talking to himself. More often, the "team" is used as a shibboleth when in fact there is not and cannot be a team simply by virtue of the relative distributions of time for the various disciplines at the clinic. There has been an ultimate blurring of roles as social workers have become junior psychiatrists—with no one doing the by now low prestige social work; as psychiatrists function exclusively as psychotherapists—with no one competent to do the neuropsychiatric evaluation; as psychologists can be distinguished from psychiatrists only by their lower earnings and lower caste. Need I argue that it is well past time for us to re-examine the training for each discipline in relation to its actual professional function²⁴ and to utilize whatever special skills each might have in relation to the real problems of real people? Do we offer something tangible and useful to those who seek our help or are we con-

tent to "cool them out"? With growing shortages of manpower and with the growing press of claimants for service, it would indeed be a mockery to waste our human resources on busy work. The crying need is for rigorous studies evaluating outcome as we introduce new clinics, new services, new programs for community mental health.¹⁹

A posteriori, it is easy to see the faults of an earlier era and to overlook the devoted efforts of the legion of dedicated workers who applied what they believed to be true in a humane effort to ameliorate the distress of children. For that, all credit to them. Most of us can do no better than reflect the social perceptions of our times. The past quarter century, marked by the defeat of fascism and the upturning of economic indices, was one of social optimism in which the poor disappeared from American consciousness if not from the slums of our cities. The publication of Michael Harrington's ²⁶ *The Other America* in 1962 can be taken as a convenient marker for the cresting of a wave of public concern for the poor and the black which has given new impetus and more productive directions to research in child development.

I am convinced that research in cognitive and personality development as resultants of the interaction between experience and maturation has been the major productive thrust of the past decade. If we psychiatrists are to contribute to the welfare of children, these are the areas in which the most is to be learned and the most to be given.

Just as the moral treatment of the insane had flowered and died a century before we were to rediscover it as "milieu therapy" and "community mental health," the antecedents of contem-

porary concerns with the effects of exogenous factors on cognitive development trace back at least that far.²⁵ But with the explosive demographic changes in the postwar period—the migration of the poor into center city areas, the flight of the affluent into suburbs and the decline in the urban tax base—the public school crisis has provided a new imperative for a long-standing issue.

Whether one examines IQ scores, achievement test results, years of schooling, or almost any traditional index of academic success, one finds marked differences that co-vary with the social class of the child.³¹ Given the millions of children who are performing at marginal levels on the standard measures of academic achievement,^{12, 64} it becomes an urgent matter to identify the source of this human wastage. In a necessarily brief scan of recent research, I propose to touch upon the following issues: test bias, prenatal and paranatal factors, postnatal nutrition, family style, the school and, finally, the effects of racism.

Logically, the first question to be raised is whether test score differences are "real" differences or merely artifacts of measurement. The answer depends upon what we suppose that the tests measure. If it is "innate ability," as the naive psychometrist may assert, then intelligence test score differences are simply irrelevant, since they register the interaction between biological potential and experience, with no way of distinguishing the one from the other.²⁰ The pragmatist may assert nonetheless: what matters is the functional result, whether it reflects environment, heredity, or both. Are the functional differences real? Again, the answer will be different for different measures. Pose the question this way: 'Are there real

deficits in ability to solve standard arithmetic problems or to read standard English paragraphs? The answer is an unequivocal: "yes." And this answer is a significant one; for, whatever other skills an adult may have, if he cannot use and read standard English, he will be seriously handicapped in negotiating the middle-class terrain where the material rewards of society are to be obtained. But there remains another question of major importance: Is the child impaired in his ability to reason, or do the language and the symbols in which the problem has been coded account for his performance failure?

It is by now abundantly clear that there *are* major differences in syntax as well as in vocabulary between middle-class and lower-class languages⁵ and between white and Negro dialects.^{2, 66, 69} I would caution you against the widespread assumption that what is different is defective. Lower-caste language may be dysfunctional in a middle-class world but it may also convey every subtle nuance of meaning within the indigenous culture. However, the Negro child attending first grade may be facing the task of learning a new language as well as of learning to read, at one and the same time. If this analysis is correct, it may account in part for his performance breakdown; Mexican Indian children learn to read more readily if they are taught with primers transcribed in their own dialect rather than in the Spanish they are just beginning to master.⁴⁵

Moreover, a former colleague of mine, Professor Sonia Osler,^{50, 51} has demonstrated that lower-class children are able to profit from training (in learning to solve a concept problem) quite as well as middle-class children with a mean IQ some 15 points higher. Indeed, she calls our attention to how

much *less* often there is any report of deficit when tasks involving *new* learning are given to such children in contrast to tests reflecting cumulative accomplishment. In our own studies²¹ on children in Project Head Start, we have demonstrated statistically significant gains in such measures of "IQ" as the Peabody Picture Vocabulary Test and the Goodenough-Harris after no more than a 10-week enrichment experience. I do *not* mean to maintain—and indeed I do *not* believe—that there are *not* significant impairments in the academic function of some of these children by the time of school-leaving age. But I would emphasize that (1) the differences are exaggerated by the linguistic code factor and (2) the ability to learn is preserved to an extent far greater than conventional test scores are able to register. Both of these propositions have important implications for compensatory education programs.²⁵

The second series of studies salient to this review concerns the prenatal and paranatal factors that influence brain development. Professors Pasamanick and Knobloch,^{89, 52} in a masterful series of investigations, have identified a "continuum of reproductive casualty" that extends at one end from spontaneous abortion and stillbirth, through mental deficiency and epilepsy, to learning disabilities and behavior disorders at the other end.

The underlying brain injuries are related to complications of pregnancy and parturition (toxemia, bleeding, infection, prematurity), complications which occur at significantly higher risk among the poor, the black, the unmarried, the underaged, and the overaged mother. These complications appear to result from an interaction

between inadequate diet, poor prenatal care, poor housing, and gross stress, each of which is associated with pregnancy outcome.⁷⁰

Sequential followup studies^{73, 74} have provided unequivocal evidence that the low birth-weight infant shows a high rate of neuropsychiatric disorder which results in serious impairment of academic performance.

But the hazards that surround the perinatal period—unacceptable and needless as they are—should not be mistaken for the major source of academic failure. In a recent 10-year followup of a pregnancy cohort in Kauai, the authors concluded: "The overwhelming number of children with problems at age 10 had relatively little or no perinatal stress, but they had grown up in homes low in socioeconomic status, educational stimulation, and emotional support."⁷²

The third related area of research centers on nutritional factors, both before and after birth. Although earlier studies of maternal diet during pregnancy had been inconclusive because birth-weight was used as the outcome measure, recent studies^{9, 10} have indicated that low protein diet during pregnancy can lead to permanent stunting of subsequent adult stature even in animals not noticeably different at birth. A diet deficient in protein during the nursing period can induce permanent stunting in whole body and organ growth even when a free diet is made available to the young after weaning. Although the brain is proportionately it does show significant growth retardation less influenced than is total body weight, and the affected animals display poor performance in problem-solving situations.¹⁵

To turn to human data, the developmental quotient of children with kwashiorkor is markedly retarded and may not recover even after dietary repletion.¹⁸ In a study¹⁴ of children whose stature was taken as an index of earlier nutritional impairment, the authors found significant developmental delay in intersensory integration. More recently, Winick,⁷⁵ employing DNA (deoxyribonucleic acid) content as a measure of cell number, has shown that there is a marked restriction in brain cell growth in malnourished infant animals. Careful DNA measurements on human infants adequately nourished but dead of poisoning or infection has indicated that brain cell number continues to increase until five to six months of age. When these control values were compared with those from five children who died of severe malnutrition in the first year of life, there was a marked reduction in the number of brain cells in these infants, two of whom demonstrated a cell number less than 40% of normal!

Thus, it would appear that severe protein deficiency may wreak its havoc on intellectual development by interfering with cell multiplication during these crucial early months of development. The question that remains to be answered is whether this is a threshold phenomenon, appearing only when protein malnutrition exceeds some set value or whether it is graded and may appear in moderately malnourished children. Professor Monckeburg⁴⁰ of Chile has recently reported an association between developmental level, physical growth retardation, and level of protein intake as measured by careful dietary histories.

Here we confront a problem of worldwide significance, applying not only to the savage starvation that obtains in the

underdeveloped countries but as well to the malnourished youngsters who populate Appalachia, the black ghettos of our cities, the black belt of the South, the Indian and Eskimo reservation of North America, and the Mexican-American and Puerto Rican enclaves scattered through the United States.^{30, 47} All of the facts may not be in, but those we do have demand a massive commitment by the wealthy nations of the world to ensure that no child starves. To await the final refinements in nutritional research is to condemn another generation of children to intellectual crippling—in Biafra, in Guatemala, in India, in pockets of poverty in our cities. Even as we study, we must act. We, who as students of development are aware of the grim toll of malnutrition, must take the lead in persuading our governments of the urgency of prompt intervention.

The fourth area of study moves us from the biosocial to the psychosocial sphere. The urban slum child grows up in a home bereft of books and often of newspapers, restricted in geographic experience to the few blocks surrounding his dwelling, denied stimulating cultural vistas, and limited to learning a nonstandard language.^{32, 38} His parents, like himself, are likely to have been earlier victims of limited educational exposure and to have cognitive styles which differ significantly from those modal for the larger society.

Professor Hess,^{27, 28} now of Stanford University, has conducted a number of significant studies employing the technique of direct laboratory observation of mothers and their 4-year-old children during sessions in which the mother was asked to teach each of three simple previously mastered tasks to her child. Her strategies of control, her teaching styles,

her language, and her affective behavior were carefully observed during this interaction. As expected, the middle-class children performed at higher levels on a variety of measures than did the lower-class children, all of them Negro in these studies. There were clear associations between maternal control strategies, teaching styles, language, and affective behavior and the child's test performance.

It should come to us as no revelation that the mother is the child's first teacher, but to say this is not to have identified the particular aspects of the mother-child relationship which are significant in the learning process and thereby to have indicated the critical points at which guided intervention can improve her skills. The work of Professor Hess has moved us a significant step in this direction.

Thus far, we have presented evidence that the child arrives at school already different in his mode of function from the middle-class child for whom teaching styles have been designed. What of the effect of the school itself? School administrators are wont to displace the responsibility for his subsequent failure on to the "defects" of the child, whether they assert those defects to be congenital or acquired. Although it is somewhat more fashionable today to lay the blame on the home, the vehemence with which the defect theory is asserted implies the inherent nature and the incorrigibility of the defect.

That the schools have not succeeded in helping the child who arrives at its doors different from the middle-class norm is clear enough from the school achievement studies and dropout rates described earlier. Not only do they not succeed in reducing the achievement

gap, but the test data demonstrate an ever-increasing disparity.¹² Can it be that the overcrowded, understaffed, undersupplied, and discipline-oriented schools found in the urban slum may in fact actively contribute to a child's failure? I cannot here review an extensive literature which suggests that this may indeed be the case,⁵³ but will call attention to several representative studies.

In the Head Start research referred to earlier,²¹ Dr. Keith Connors was able to demonstrate that the amount of improvement in a class of children could be correlated with measures of the teachers cognitive, disciplinary, and affective styles. Unhappily, the characteristics associated with better performance were those incompatible with the rigid authoritarian attitude of urban school teachers suggested by a survey of teachers carried out at the same time. Anecdotal reports and clinical experience suggest that many school teachers expect little and are not surprised when they get little from black children. And yet the importance of expectation has been demonstrated to be a major influence on performance.⁶⁰

In a California study, Professor Rosenthal⁶¹ and his associates administered a pretest to first grade children, a number of whom were chosen at random to be identified to their school teachers as being likely to show great improvement during the school year. Not only did the teachers (in rating these children at the end of the year) describe them in more positive terms but the children themselves performed significantly better on achievement tests at the end of the year. And yet chance alone had dictated the selection of these "bloomers." The investigators did not, as ethical considerations dictated, single out other

children as dull or likely to fall behind. But the data from this study, together with a wealth of supporting material from other studies on social expectation, make it clear that depression of scores would have been recorded if such a companion study of likely dullards had been attempted.

I suggest to you that such a "study" has been being carried out for the past 50 years in public education because of our failure to imbue teachers with a concept of cognitive development that emphasizes its dependence upon the positive reinforcement of appropriate experience in the context of a warm and supporting human relationship. I suggest to you that it is not the children who fail but the schools that have failed, and that it is we who have failed because of our lack of involvement in the critical area of teacher education.

The final—and in many ways the most important—factor in this saga of human waste is racism: the attitudes and beliefs that deny full humanity to those who differ from us in color or culture. It is little comfort for Americans to recognize that this is a phenomenon found in Britain as well as the United States, in Nigeria as well as in South Africa, in India as well as in Poland, in Israel as well as in Egypt. The bio-social and psychosocial factors thus far discussed are intertwined with racism. True, they occur even in its absence; witness the deprivation experienced by the poor regardless of ethnicity. But the intolerable burdens are multiplied by the housing ghettos, the employment barriers, the lower pay scales, and the barrage of psychological insult directed against those who are visibly different.^{11, 66}

Given the greater biological hazards and the cultural differences that militate against attaining economic success, the further assault of a dominant culture that systematically degrades the characteristics that establish one's identity makes the task of growing up whole a particularly difficult one for the black child.⁸ If one is to attain a sense of potency—a conviction of one's manliness or womanliness—one must have a belief in the effectiveness of his own efforts as a determinant of personal attainment. But how can a conviction of personal competence be attained when skin color if one is black, automation if one is unskilled, illness if one is denied medical care, false imprisonment if one cannot obtain legal assistance—all issues beyond personal control—destroy the job, the savings, the dreams of the hardest working and the most diligent?²²

There is one antidote that may serve as a soul-saving measure while the major struggle for human dignity is being fought. And that antidote, not without its own toxicity, is pride in race. We have begun to observe the growing strength in the United States of a movement that asserts that black is beautiful and that African culture is better than Western. United by common beliefs, black communities have begun to assert the rights of local control in policing, business interests, schooling, and urban planning. I count all of this a distinct *psychological* gain for the black and for the white community; whether it will succeed *politically* is still an open question.

When we turn to the public school crisis, we find the movement for local autonomy confronted by the vested interests in job and tenure of the educational establishment, from the most un-

derpaid teacher to the most prestigious school-board member. Mechanisms to enable both local control and job security to survive remain to be invented, but a significant shift in power is inevitable. In essence, the black community confronts us with these incontrovertible facts: integration has not moved forward in meaningful fashion in the 15 years since the Supreme Court decision; black children are not learning effectively in the schools run for them by the white establishment; the longer they wait for "goodwill" and "gradualism," the more their children will fall by the academic wayside. Could black run schools do worse? I do not believe so. Successes have been attained by "street academies" established by militant volunteers. There is, as I see it, good reason to support black power. It accepts the segregated housing patterns and school distributions as unavoidable phenomena of the near future. At least some of the spokesmen for black control anticipate a time when reunion and reintegration will be possible once the blacks have obtained political power as attested by the history of each of the immigrant groups to these shores. Will this prove to be true? It is the more likely to be true the greater the commitment of professionals to its success. It will provide us with a unique opportunity to study the interaction between self-concept and personal development if we make ourselves available to the new schools as contributors to their growth and investigators of the progress of their pupils. For they, no less than we, will want to learn where they succeed and where they fail and what will accelerate their development. Mind you, this will require that we be willing to learn even as we teach, that we abandon the arrogance of our own pretensions as standard bearers,

that we become active participants and not merely "neutral" observers.

To close on a historical note, I would recall to you a paper written 35 years ago by Joseph Brenneman,⁷ a distinguished pediatrician of his time, who gave his paper the ominous title "The Menace of Psychiatry." He decried the armchair speculations, the absence of empirical data, and the confusing psychological theories that served only to upset parents and alienate pediatricians. In response, James Plant of the Essex County Juvenile Clinic wrote "The Promise of Psychiatry." His concluding paragraph included these statements:

We are, as a people, going through great changes in the matter of human relationships. Whether you like it or not, the families which are your clientele are finding themselves face to face with new and profound social problems. These matters affect the conduct and health of the patients and serve to make every family part of our clientele, because every family is having to adjust itself to these changes. You cannot escape these problems and their implications to the child's health by deprecating them, nor can you solve or understand them by setting up a beautiful little experimental station where they do not exist. . . . The promise of psychiatry is the promise that if the pediatrician will address himself to these problems he will face a vista of rare challenge. . . . Personally, I am sorry if he is only afraid of that challenge.⁸⁴

And now let me jump forward three decades and echo the words of Walter Orr Roberts, president of the American Association for the Advancement of Science:

Never before has the opportunity been so great. We have the knowledge and the means to achieve a living environment of unprecedented quality. And we can do this not only for one nation but for all who travel with us on this planet. I have no illusions that it will be easy to achieve what we want from

our civilization and our moment in history. It will clearly be a long and hazardous job, for scientist and citizen alike, to reach our goal for the human condition. But, as Thornton Wilder said, "every good and excellent thing stands moment by moment at the razor edge of danger, and must be fought for." Can we not wage the right kind of fight for the goal of the century twenty enlightenment?⁸⁵

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A PARADIGM FOR THE ANALYSIS OF CHILDBEARING MOTIVATIONS OF MARRIED WOMEN PRIOR TO BIRTH OF THE FIRST CHILD

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Childbearing motivations involve a constellation of socially defined and idiosyncratic meanings, some of which may not be recognized by the individual. A systematic delineation of the multiplicity of meanings related to childbearing provides a framework for investigating motivational conflicts that may thwart childbearing plans and contribute to problems of conception, pregnancy, childbirth, and childrearing.

Availability of acceptable means for preventing conception permits childbearing to be a consequence of motivated human action rather than a mere biological result of sexual behavior. Whether pregnancies occur only after a period of deliberation or result from nondeliberative behavior, the number of children a couple has and the time at which they have them are partially a function of the nature of the couple's childbearing motivations. Conflicted childbearing motivations may contribute

to the occurrence of problems during various stages of the reproductive process. The inability to conceive or carry a pregnancy to term, the inability to prevent conception when a child is not consciously desired, aberrant somatic reactions during pregnancy, labor and childbirth complications, postpartum depressive reactions, and inadequate or detrimental maternal behavior may each, in part, be a function of childbearing conflicts. A greater understanding, therefore, of motivations and conflicts per-

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taining to childbearing offers the prospect of improving educational, medical, and social agency programs for the prevention and alleviation of reproductive-related problems and the cultivation of more rational and effective family planning behavior.

A conceptual focus on childbearing motivations and conflicts integrates a research program on family formation and development being carried on by the author in collaboration with Viola W. Bernard, M.D.* The program consists of a longitudinal investigation of married couples, beginning prior to the conception of their first child and continuing through the early period of parenthood. The aim of the longitudinal series of studies is to identify configurations of childbearing motivations and conflicts associated with differential childbearing plans, behavioral and somatic reactions during successive stages of the reproductive process, and subsequent patterns of maternal behavior.

CHILDBEARING MOTIVATIONS AS A FOCUS OF RESEARCH INTEREST

There has been little systematic research focused directly on the nature of childbearing motivations and conflicts. The research most relevant to motivations for childbearing has come primarily within the scope of two divergent methods of inquiry: (1) social-demographic surveys and (2) psychoanalytic case studies.

Social-Demographic Surveys: One aim of social-demographic surveys has been to account for differences in the number of children desired by individuals or the family size they consider to

be ideal. These surveys have successfully identified variations in the average number of children desired by population groups differentiated in terms of religion, ethnicity, education, occupation, residence, nationality, rural/urban background, and socioeconomic status. The findings leave unexplained the variation of family size preferences among *individuals* within any given population group. Since no combination of social variables adequately accounts for this variation, a number of psychological factors have been related to family size preferences.

The first large scale social-demographic survey related to family size preferences was carried out under the direction of Whelpton and Kiser.¹² The psychological conditions they assessed included "feelings of personal inadequacy," "liking for children," "ego-centered interest in children," and "fear of pregnancy." Westoff et al.,¹¹ in a recent extensive and methodologically sophisticated social survey, related a number of personality attributes to desired family size. These investigations found no substantial associations between psychological factors and planned or achieved family size.

In appraising these studies, Kiser⁶ and Westoff¹¹ have asked whether the failure to find psychological conditions associated with reproductive plans and performance might be due to the absence of a valid theory, to the choice of irrelevant psychological factors for study, or to unreliable assessments of these factors. Hill et al.⁴ have questioned the validity of assessments of "ideal family size," the independent variable which

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social-demographic surveys are designed to explain. They indicate that the inconsistency of response they found probably reflects ambiguity and ambivalence of attitude about family size, and that "simple statements of family size preference, while not meaningless, are deceptive in a context where attitudes may be uncrystallized or ambivalent."

To elaborate on these methodological criticisms, it may be noted that if personality attributes are related to family size preferences, the relationship must be mediated through an individual's motivations for childbearing. Similarly, social-economic conditions can only affect reproductive plans if the conditions are construed as motivating considerations in a couple's childbearing decisions. A study of differential childbearing motivations would therefore seem to be the most fruitful research focus for identifying the psychosocial conditions associated with differences in the number of children desired. However, the nature of childbearing motivations must first be conceptually analyzed if they are to be reliably and validly related to family size plans.

Hoffman and Wyatt,⁵ in trying to account for a recent increase in family size in America, have hypothesized that three social trends may have resulted in motivations for having larger families: (1) changes in the woman's role, (2) changes in the parent role, and (3) an increase in loneliness and alienation. Although not designed to test the Hoffman-Wyatt hypotheses, Rainwater's studies provided evidence for a relationship between women's family size preferences and their orientation to the woman's role and to the parental role.^{9, 10}

Psychoanalytic Theories: In contrast to social-demographic research, which is designed to account for the differential number of children women desire or plan to have, psychoanalytic theories are constructed to explain the desire of women for a child. To explain family size preferences, social-demographic studies focus on differential psychosocial conditions; to account for the wish for a child, psychoanalytic theories focus primarily on development experiences (usually assumed to be universal) and on the postulated maternal drive or instinct.

Most psychoanalytic explanations begin with Freud's theory which may be briefly outlined as follows: The little girl, upon discovering that she doesn't have a penis, desires to rectify her anatomical defect by obtaining a penis from her father. However, she equates the penis with a child and comes to desire a child by her father instead. This wish, if successfully repressed, emerges as a desire for a child in an adult heterosexual relationship. The psychoanalytic literature which has drawn on, elaborated, and added to Freud's theory is too extensive to be critically analyzed in the context of this paper.* But a few of the most recent formulations of the nature and development of the wish for a child will be reviewed briefly.

Most psychoanalytic theories of maternal motivation assume a biologically given reproductive drive. Benedek³ has detailed a specific physiological basis of a reproductive drive, in indicating that hormonal changes which accompany ovulation periodically prepare women for motherhood and constitute physiological stimuli of a woman's desire for a child. The wish for a child is presumed

* Wyatt¹⁸ has provided an excellent review of psychoanalytic theories pertaining to motivations for childbearing.

to be triggered off during the progesterone phase of the ovulatory cycle.

Pollock⁸ describes the nature and ramifications of the need for reproduction as follows: "In the unconscious of man every intercourse is still related to conception and reproduction. The sexual pleasure-seeking drive, though intimately related to the reproductive drive, has its own developmental history and the two must be distinguished. . . . The reproductive drive may be blocked because of intrapsychic conflicts (i.e., unresolved sibling hostilities, unresolved oedipal conflicts, identifications and counter-identifications), physical inabilities, or external reality factors . . . when the reproductive drive is unfulfilled either directly or symbolically, we may find evidence of narcissistic pathology. Since the issue of reproductive and procreative needs is additionally related to the future, to immortality, to denial of death and nothingness, problems in these areas may be reactivated in instances of sterility. . . . Thus, such apparently unrelated areas as reincarnation, property rights, kinship lines, parental motivation of children's name selection, mourning, memorials and monuments have unifying connections with reproductive drive and perpetuation into the future."

Some of the formulations by Lerner et al.⁷ of the "need to be pregnant" include the following: "A woman may become pregnant primarily to gratify infantile needs for affection. . . . Damage to the body image may be repaired by identification with the perfect fetus. The swelling of the abdomen can represent a newer inner growth, a penis, that makes a pregnant woman feel complete and overcomes an existing sense of castration. Identity as a woman may also

be concretely strengthened by success in proving that her feminine reproductive ability is intact. . . . A woman may want to become pregnant as a way of competing with other psychologically significant female rivals. On a deeper level is the well-known fantasy of the penis-child, which a woman may invoke in competitive masculine power strivings. The ability to create life itself in an entirely new human being can give a needed and reassuring sense of omnipotence to a weak ego. . . . Pregnancy may be used as a means of self-punishment for various guilty thoughts and deeds over nonsexual as well as sexual impulses and actions."

Wyatt¹⁸ has described a component of a women's motivation for children as a "Principle of Inner Duality." "Inner Duality pertains to our capacity for splitting the self into two prototypical roles so that it can reenact and revise certain elementary relationships. . . . The little girl playing house with her dolls provides a simple example: the covert aim of her play is to be both the mother *and* the child. She relishes both roles for the needs they gratify and uses them to integrate experiences and to resolve a variety of tensions. Her next step in the development of inner duality is to extend it to another person who is then not only the "object" of wishes but, much less visibly, also the one to whom a part of one's self has now been assigned. . . . In time, tenderness, the need to care for somebody else, and the wish for the child all become *autonomous* in G. W. Allport's sense—they become relatively succinct, articulate and explicit motives in their own right. But their origins can be as clearly discerned—if properly looked for—as

those of other motivational strands contributing to the child-wish."

In addition to the theoretical writing from a psychoanalytic framework, psychoanalytically oriented case studies have provided a rich source of hypotheses which specify motivations and conflicts pertaining to childbearing. Especially illuminating have been reported cases of functionally infertile women² and out-of-wedlock pregnancies.¹

ASSUMPTIONS CONCERNING CHILDBEARING MOTIVATIONS

The paradigm described in this paper for the analysis of childbearing motivations and conflicts is based on the following assumptions:

1. No quasibiological entity which may be hypothesized as existing within the individual, such as a maternal instinct or maternal drive, can account for motivations for childbearing.

2. Childbearing motivations can be understood only in the context of a woman's appraisal of her current life-situation and the changes in her life-situation that she expects childbearing to bring about. More specifically, a woman is motivated for or conflicted about childbearing by a constellation of meanings she associates with biological changes initiated by conception, and with personal and interpersonal changes initiated by motherhood.

3. Some of the meanings a woman associates with childbearing may be articulated as reasons for wanting a child or as reasons for postponing or avoiding childbearing. These reasons may be primary considerations underlying a woman's childbearing intentions, or they may simply justify a childbearing decision. A woman may or may not recognize the multiplicity of diverse meanings

which motivate her for childbearing, make her reluctant to bear children, or induce childbearing conflicts. These meanings are directly or indirectly revealed in memories, expectations, beliefs, values, desires, hopes, concerns, fears, dreams, and fantasies pertaining to pregnancy, childbirth, motherhood, and childrearing.

4. The various meanings and anticipations pertaining to childbearing and motherhood may be more or less compelling or salient in generating a woman's childbearing intentions or conflicts. Some changes initiated by pregnancy and motherhood may be anticipated simply as desirable or undesirable consequences of a childbearing decision, without being motivating considerations for the decision.

5. No universal set of motives are assumed to account for reproductive behavior. Depending upon a woman's developmental life-experiences, current life-situation, and culturally given beliefs and values, any constellation of meanings can be associated with childbearing and motherhood. The prevalence of common meanings among any group of women are assumed to be a function of similarities in past and present life-situations and in social evaluations pertaining to childbearing.

6. Motivations and conflicts pertaining to childbearing and motherhood change with each successive reproductive experience. That is, the experience of pregnancy, labor, childbirth and motherhood alters subsequent motivations for pregnancy and childbearing.

7. Because of the multiplicity of meanings entering into childbearing motivations, both the decision to have a child and the decision to avoid child-

bearing entail some conflict, no matter how minimal.

NATURE, PURPOSE, AND LIMITATIONS OF THE PARADIGM

The paradigm outlined below consists of a set of perspectives for investigation of the childbearing motivations of married women prior to the birth of their first child. The delineations within each perspective of the multiplicity of meanings and anticipations which may be associated with pregnancy, childbirth, motherhood, and childrearing are construed as guidelines for eliciting, classifying and interrelating data pertaining to motivations for childbearing. Although a comprehensive assessment of the motivations and conflicts of any individual would require statements from the total set of perspectives, the relevance of any particular perspective for understanding childbearing motivations and conflicts would vary from individual to individual.

The paradigm has several limitations:

1. The scheme was developed from data pertaining to childbearing motivations and conflicts collected from 82 women. The women were volunteers, and therefore constitute a self-selected sample which cannot be considered representative of any definable population. Consequently the data upon which the paradigm is based may omit childbearing considerations of women who do not volunteer to be studied, and of women

in ethnic groups not represented in the group of volunteers.*

2. The various perspectives outlined for the analysis of childbearing motivations and conflicts and the considerations delineated within each perspective were derived from a content analysis of statements elicited by the following two data-collecting procedures:

FOCUSED RECOLLECTIONS

The subject is asked to recall all the thoughts and feelings she has had about "having and not having children." Three broad time periods are specified: (1) When you were a little girl. (2) As you were growing up. (3) More recently. The above instructions are repeated in turn for the following concepts: pregnancy, labor and childbirth, and being a mother.

INTRA-SELF DIALOGUES

The subject is instructed to formulate a series of questions directed toward herself and then to answer a tape-recorded playback of these questions. For example, a woman is told to pretend that "another part of herself" is sitting in a chair opposite her. She is then instructed to ask that "other part of herself" a series of questions in the form "Do you want a child in order to . . .?" or "Are you reluctant to have a child because . . .?" Her audio-recorded questions are then played back to her, one at a time, and she is instructed to respond to each question as completely and fully as she can and to verbalize whatever thoughts are evoked by the playback.†

Although these procedures were found to be effective in eliciting many private and frequently concealed thoughts and fantasies related to childbearing, there are

* Of the 82 women studied: 68 were white, 12 Negro, and 2 Puerto Rican. 23 were Protestant, 18 Catholic, 34 Jewish (7 could not be classified in any of the three major religious groups). 4 had not completed high school, 18 were high school graduates, 20 had some college education, 28 were college graduates, 12 had done some graduate study. The mean age of the group was 28; the age range was 20 to 41. The mean years married was 4, and the duration of marriage ranged from 1 to 14 years. The women were differentiated in terms of fertility-status and performance as follows: 8 women who had recently ceased using contraception in order to become pregnant; 5 pregnant women whose conception was planned; 2 pregnant women whose conception was unplanned; 32 women who were postponing or avoiding childbearing; 36 women who were unable to conceive or carry a pregnancy to term.

† These and other data-eliciting strategies developed for studying childbearing motivations and conflicts will be reported in detail elsewhere.

meanings which some women may associate with successive stages of the reproductive process which they may not have been willing or able to disclose in the research situation provided.* Consequently, it is assumed that inferences made about unexpressed or unrecognized meanings implicit in the verbal reports, or a translation and synthesis of the statements made in terms of a theoretical set of constructs, would generate additional meanings, associated with conception, pregnancy, childbirth, and motherhood. To incorporate unexpressed meanings in the paradigm, transcriptions of verbal reports elicited by the two procedures outlined above, as well as by other interview techniques, are being psychoanalytically interpreted.

3. Since many of the individually listed perspectives in the paradigm are interrelated, the scheme would have more instrumental value if it were organized in terms of a typology of motivational considerations for childbearing. The data are currently being analyzed in order to discover relationship patterns for constructing such a typology.

DELINEATION OF THE PARADIGM

Within each perspective of the paradigm, a number of alternative motivational considerations are delineated. Since the motivational considerations viewed from the various perspectives are in many instances integrally related, some considerations listed under one perspective could have been included under another. A few alternatives within each perspective are illustrated by brief

verbatim case-excerpts, abstracted from extended verbal reports.

SOCIAL EXPECTATION OF CHILDBEARING AND MOTHERHOOD

Although women are increasingly free to choose alternatives to motherhood as a way of life, childbearing is still socially defined as the "normal," "natural," if not primary function of women. Women who delay having their first child beyond some conventional period of time or who entertain the possibility of remaining childless become keenly aware of the social expectation of childbearing and the disapprobation of childlessness. The childbearing expectation, learned from both example and precept, may simply be taken for granted as an expected stage in a woman's life; on the other hand, a woman who questions the inevitability or desirability of childbearing may still feel compelled to conform to the social expectation to bear children. The refusal to conform may induce feelings of guilt and self-doubt.

I just always thought I would have children. I never thought I wouldn't. It was always part of my life when I wheeled my doll carriage and I pretended that they were my babies. . . . I just thought that I would go to college and get married and have children and I never really thought about it except that's just the way it would be.

This society makes it being a bad girl if you don't have children. It's all right as long as there is some very practical reason why you don't want to have children. I mean it's very chic to put it off so that you can make money, or so a husband can get a degree or something, but one is made to feel something of a

* For example, although fantasies and dreams of having sexual intercourse with one's father were disclosed, the wish to have a child by one's father was only reported by several women who had been in psychotherapy. Since the paradigm developed was intentionally limited to verbal reports taken at face value, a wish to become pregnant by one's father and other childbearing motivations which would be inferred from a psychoanalytic framework were not included.

bad girl for not fulfilling her biological identity.

When I think about myself having a child, it's not so much for what I'll be getting out of the experience, but for what other people will say. As far as I'm concerned at this period in time, if I were having a child now, the reasons would be to gain approval from this person, that person, society as a whole—because it's rather difficult, even in this "enlightened" age, to be married and childless. You're doing something sort of asocial by not having children. People tend to ask you questions and I walk around with just a slight feeling that I'm doing something wrong.

CHILDBEARING AMONG PEERS

A childless woman may wish to emulate her friends or relatives who already have children or she may be supported in her desire to postpone childbearing by the fact that her friends are also childless. She may feel isolated from friends who have become mothers, and may desire a child in order to be able to participate in activities and conversations with other mothers. On the other hand, she may disparage the social life of mothers, which centers around their children.

Once my friends started having children I became much more aware of the fact that it was about time that I had one. And even though we had been talking about it before this rash of pregnancies appeared, I think I became a little bit more anxious about becoming pregnant sooner.

If you don't have children you seem like on the outside of everything. As much as you socialize with them, the conversation always comes back to children, and did the kids do this or did they do that, and you always seem left out of that conversation.

IDENTITY IMPLICATIONS OF CHILDBEARING AND MOTHERHOOD

A woman may be confident of her femininity, and look forward to childbearing as a further confirmation of her feminine identity; she may doubt her

femininity, and require childbearing as a demonstration of her adequacy as a woman, or as a sign of being grown-up; or she may question whether childbearing is necessary for her identity as a woman. A woman may desire motherhood as a substitute identity for unachieved career aspirations; or motherhood may be derogated as commonplace in comparison with her identity as a person or as a career woman, in which case she may postpone childbearing indefinitely rather than risk jeopardizing her more valued identity. If a woman has no life interests or plans that compete with motherhood, she may be unconcerned about motherhood as a way of life. If she does have valued interests or life involvements that would be restricted by motherhood, she may experience a conflict whether she subordinates her other interests to motherhood or continues to postpone childbearing.

I say to myself, "Women have children and you're not too secure about your role as a woman and therefore you should have children just to have some kind of certification of your womanhood."

There are many kinds of fulfillment besides having children. You may choose another kind altogether. Having children is part of why you're a woman all right, but just because you're something, it doesn't mean that you necessarily have to do everything that goes with it.

IDENTIFICATION WITH A FANTASIED CHILD

A woman may look forward to having her own characteristics reflected and perpetuated in a child, or she may construe childbearing as an opportunity to compensate for the inadequacies she feels in herself by rearing a child who will achieve what she has not been able to or will become the kind of person she

would like to be. On the other hand, a woman who depreciates herself may be reluctant to bear children for fear that her child would grow up to be like herself, with inadequacies similar to her own. Depending upon a woman's evaluation of herself, she may or may not desire a biological continuity through childbearing as a kind of immortality.

I'd feel pride in new accomplishments that my children learn. You can't help but think of them as being a reflection of yourself and sort of part of you.

I'm not even sure I want to be myself, let alone making some other person reflect my image. I suppose self-love has a great deal to do with childbearing. Maybe if I was confident about myself as a person, then I would want to have children as an extension of this self.

I am terrified that if I did have a child, the child would be like me. So, I have no real desire to have a child.

CHILDHOOD MEMORIES AND IDENTIFICATION WITH OWN MOTHER

A woman who admires her mother may want children in order to become a mother like her own. She may look forward to experiencing the fulfillment that her own mother experienced through motherhood, and want to reproduce the relationship with her children that she had with her mother. She may want to raise children who will have and enjoy the kind of experiences she had as a child, and in the role of mother to reproduce the happy family life she experienced as a child.

A woman who views her mother as having been inadequate and unhappy in motherhood may fear that if she became a mother she would be equally inadequate, and would experience motherhood primarily as a burden and sacrifice. She may be afraid that in the role of

mother she would reproduce the same unhappy family life she experienced as a child; that she would reestablish the undesirable relationship with her children she had with her own mother; that her children would be as unhappy as she was as a child.

On the other hand, a woman who considers her mother to have been inadequate and unfulfilled in motherhood may look forward to childrearing as a means of demonstrating her ability to be a good mother in comparison to her own mother. In the role of mother, she may determine to create a family life different from that she experienced as a child and establish a more satisfying relationship with her children than the one she had with her own mother. She may want to prevent her children from having the kind of unhappy childhood she experienced, and wish to provide them with experiences she missed as a child.

I always wanted children. When I was little I said I always wanted to be a mother. I guess because my mother was so great, I wanted to be like her.

My mother worries excessively and is excessively fixed on her children. That doesn't mean that, even though I do see myself as a worrier, that I'm going to be extreme. I've gotten a lot of negative attitudes about children from my parents. But I don't necessarily have to relive my parents' experience.

I didn't have this parent-child love relationship. And I don't think it's in me to have it because of the way I was brought up.

CHILDBEARING ANTICIPATIONS AND EXPECTED RELATIONSHIP WITH CHILDREN

A woman may have a vague, undefined sense that she would be missing something in life if she has no children, or she may anticipate specific satisfac-

tions and fulfillments from motherhood. She may look forward to the tasks of childcare or to the physical contacts of holding, hugging, and cuddling an infant. A woman may desire a child in order to have someone toward whom to express love, affection, or tenderness; she may feel a need to nurture someone who is small and dependent. She may look forward to observing the growth and development of a child as an exciting life experience, or childbearing may be anticipated as an opportunity to guide, to teach, or to contribute to the development of another human being—the growth and development of a child being viewed as a creative achievement.

If I didn't have children I feel that I would be deprived of one of the most unique experiences of life. But because I've never had a child, I can't fully realize what I'm missing. I can only think, yes, there must be marvelous things that I know nothing about. I can only guess at it.

Secondary to the rewards of just having a child are the satisfactions of loving it, having it love you, holding it, watching it grow, watching its mind develop.

Or, rather than anticipating satisfactions from childrearing, a woman may view motherhood primarily as a burden and a sacrifice, and childcare may be anticipated as boredom and drudgery. A woman may be concerned about the loss of time to engage in activities which she enjoys, or the restrictions on her freedom to travel or to come and go as she likes. She may anticipate economic restrictions on her life imposed by the costs of raising children or by the loss of income from a job which she would have to give up if she had a child.

A baby seems to be such an endless round of bathing it, powdering it, and washing and sterilizing bottles. It just seems utter tedium. Its the idea of having to be washing up and to be a drudge, that's the thing that really

frightens me the most. The idea that I'm stuck with that little thing.

With a child we won't be quite as free as we were before. We're kind of carefree. We can pick up and go at the drop of a hat. We'll be giving up a certain amount of freedom, our routine will change; we can't just sit down if we feel like sitting down.

A woman may want a child to play with or to enable her to engage in the kinds of activities that a child enjoys. She may want to reexperience the experiences of a child vicariously; on the other hand, she may wish to share with a child the kind of experiences she herself engages in and enjoys.

A woman may feel lonely, bored, and discontented, and hope that a child will fill the emptiness of her life. She may look forward to the responsibilities of parenthood to provide meaning, significance, and purpose to living. She may want a child for companionship, to have a close and dependable relationship, to feel loved and needed or looked up to, or to have someone whom she could consider exclusively hers.

Sometimes I feel alone, so I always think if I had a child maybe I can play with it or talk to my child and not be so alone. I can't talk to my husband or to my family. But I can play with a child and not be alone.

If you have a child, it's someone to care for, to dress and feed and shelter; then you do have a real necessity for living and a feeling of responsibility to another individual.

A woman's appraisal of her own competence for motherhood may affect her childbearing motivations. She may feel that she has the abilities and personal characteristics for coping with the tasks and responsibilities of childrearing and, therefore, feel confident that she will be a good mother. On the other hand, if she thinks of herself as impatient, irritable, nervous, inconsistent, unstable, or of poor health, or views herself as having

no childcare skills or knowledge about children, then she may fear that she would be inadequate as a mother and not be able to care for children properly.

I think I would make a very good mother. I don't have any trouble getting along with children. I enjoy doing things with children, teaching them, spending time with them, holding them, cuddling them.

I'm just afraid of how to bathe them, how to feed them, whatever. I just don't know what to do. I don't even know how many times a day you feed a baby. I don't know how delicate they are. I don't know if I'm going to hurt the baby if I do something wrong.

If a woman has experienced children as likeable, lovable, interesting, or exciting, and has had satisfying relationships with them, she may simply take it for granted that she will love her own children and that they will be fond of her, and look forward to a close, rewarding, and gratifying relationship with them. On the other hand, if she has experienced children as annoying, irritating, uncontrollable, or demanding, or enjoys children for only brief periods of time, or only likes children with certain characteristics or of certain ages, she may wonder whether she will love her own children or whether her children will like her, or she may fear that she will have a conflicted relationship with her children. A woman may look forward to grown children as a source of companionship and security in her old age. She may not desire or expect gratifications from grown children; or she may view children as ungrateful, anticipating little attention from them when they reach adulthood.

I am terribly happy with children. I'm wonderful with children and children adore me. If someone gives me a child to take care of I'm in heaven. When I look out the window

and see a little child, I can weep. I just want to hold it. It's something I really feel.

I'm afraid that at many points of a child's life, it would be kind of an alien in a way, not a friend but an enemy of a sort.

I see myself in a terribly lonely state when I'm old. I'll say to myself, maybe you better take out some kind of insurance policy. Maybe it would be a good idea to have a child.

The relationships that a woman had with younger siblings may affect her childbearing motivations. She may have enjoyed playing with or helping take care of a younger brother or sister and wish to repeat these satisfying experiences with a child of her own. On the other hand, she may have resented the burdens of taking care of a younger sibling and therefore may be reluctant to assume the responsibilities of motherhood. Or she may fear that a child would constitute an intrusion and rival as did the birth of a younger sibling.

I want a lot of children. I had my little brother and I enjoyed him and I guess it's what made me think I wanted so many of them.

I resented very much my sister's coming: There was somebody else who was getting the attention of my mother and I resented the baby. . . . All of a sudden there was an intrusion of a baby and I think I still carry this feeling around to some degree today. I feel many times that a baby will be an intrusion on the life that I've sort of made for myself and which I enjoy very much.

A woman may expect the experience of childrearing to make her a more interesting person, result in her being less concerned about herself, or help her become more responsible and mature. Or a woman may expect that the tasks and routines of motherhood will limit her horizons, thwart her intellectual development, and make her a dull or less interesting person. She may be concerned

that childrearing will aggravate her undesirable characteristics by making her more irritable or nervous, affect her health adversely, or make her age prematurely.

There is something different about a girl after she has a child. A certain maturity can result from giving birth to a baby, who is completely dependent upon you.

After having a child, you don't continue developing because then your concern for the child takes over and you're no longer an individual.

MARITAL CONTEXT OF CHILDBEARING

How does a woman's relationship with her husband, his interest in having children, and her appraisal of his potential for fatherhood affect her childbearing motivations? A woman may consider childbearing to be the main purpose of her marriage, or consider her home incomplete without children. She may want a child as a symbol of the unity of her marriage or as an expression of her love for her husband. She may identify a fantasied child with her husband and want a child who will be like him. If her husband desires children very much she may want to produce a child as her gift to him; her husband's desire for children may either strengthen her motivation or overcome her reluctance to bear children. Concerns that she may have about her competence for motherhood may be allayed if she views her husband as a potentially good father with whom she will share the responsibilities of parenthood.

A woman may be reluctant to bear a child by a husband whom she neither loves or respects, or she may be concerned that a child might resemble her disliked husband. Her husband's lack of interest in having children may undermine her childbearing motivations or

support her own childbearing reluctance. If she thinks her husband wouldn't be a good father, she may be concerned about the harmful effects he would have on her children and expect that she would have to assume the entire responsibility of parenthood.

What effects does a woman anticipate or hope a child would have on her marriage? She may expect children to add satisfactions to an already satisfying marriage, or she may hope that a child will improve or secure a faltering marriage. She may want a child to provide her and her husband with common experiences and life goals—to help her and her husband grow closer together, increase her husband's love for her, or increase his interest in her home and family. She may hope that the responsibilities of fatherhood will induce her husband to change, or she may look forward to a relationship with a child as a substitute for a dissatisfying relationship with her husband.

A woman may be conflicted about childbearing because she anticipates that a child would intrude upon or disrupt the functioning relationship she has established with her husband. She may be concerned that, with children, she will have less time and attention for her husband, that she and her husband will not be able to do as many things together, or that she and her husband will have conflicts over childrearing. She may expect her husband to be jealous of the attention and affection she would give to a child, or anticipate that she would be jealous of her husband's relationship with a child. If her relationship with her husband is tenuous or if she is not completely committed to her marriage, she may anticipate that children will make a possible separation more

difficult or constitute a burden should her marriage break up.

There seems to be something so nice and so wonderful about two people loving each other and being together and being able to produce a product of this love. It's something to show for what you've been to each other, or are to each other.

I would love to see a baby that would look like my husband, it would give me a lot of pride to be able to present something to him like this.

I think that Don is kind of a child and craves my attention almost like a mother. He would feel competitive with a child.

Our relationship would definitely have to change in a lot of respects once we assume the responsibility of parenthood. The focus of attention would be entirely different. Instead of focusing on each other we'd be focusing on the child, and I guess we both like the attention we get from each other very much. The relationship has to change between husband and wife once there's a child in the family. I guess I don't want our relationship to change yet.

I really think that my husband would be a miserable, rotten father. His attitudes are inconsistent. We have cats and when the cats do something he doesn't like, regardless of whether it will do any good or not, he hits them or kicks them or pushes them away from whatever they're doing and I think this would be very hard treatment for a child.

RELATIONSHIP WITH OWN PARENTS AS A CHILDBEARING CONSIDERATION

A woman may be motivated for childbearing by her desire to please her parents who want grandchildren. On the other hand, she may be reluctant to provide her parents the satisfaction of having a grandchild. She may be conflicted about childbearing because she senses that her mother or father don't want her to have children, or have aspirations for her that would be limited by motherhood. She may look forward to help from her mother in childrearing and an-

ticipate that having a child will bring her and her mother closer together; or she may expect her mother will criticize and interfere with her raising of her child and thus exacerbate her conflictful relationships with her mother. She may be afraid that the attentions and affections of her parents will be directed away from her and toward her child or, on the other hand, she may expect motherhood to solidify her relationship with her parents. A woman may anticipate that becoming a mother will enable her to achieve independence from her own mother, or she may be concerned that the responsibilities of childrearing will increase her dependence on her.

I know my mother is forever hinting. It's like you're not getting any younger, and this girl friend or that girl friend or cousin or anybody who's having a baby, she brings it immediately to my attention. She really would love to be a grandmother. I feel responsible to her in the sense that I somehow think I ought to provide her with grandchildren.

Since our marriage my mother feels very estranged from me. She feels Bob has taken me away from her. She feels as though at times I'm a complete stranger, and I can see that this is because I'm more independent than I was when I was not married. I can see that having a baby will only make me feel this way more, so I guess it's possible that—in fact, it's likely that—my relationship with Mom will change even more after we have a child.

I feel that my father doesn't care if we ever have children, that I'm not at all letting him down by not having any. It's not important to him. . . . If I did well in a career and if I seemed happy for the work that I did, this would be satisfaction enough for him.

AGE AND YEARS CHILDLESS AS A CHILDBEARING CONSIDERATION

A woman may postpone pregnancy because she considers herself too young to have children; on the other hand, as a woman gets older her reluctance to be-

gin a family may be overcome by the realization that with further delay childbearing may no longer be possible, or that childbirth may become more difficult or even dangerous. Advancing age may constitute a motivation for childbearing not only because of anticipated reproductive difficulties, but because of the concern that one may be too old to relate to or to take care of young children. Years of childlessness due to difficulty in conceiving or in carrying a pregnancy successfully to term may intensify the desire for a child, or the years a woman is childless may increase her reluctance to have children, since child-rearing would require changes in a long-established pattern of living.

I feel as if somebody is sort of telling me, whispering in my ear that you better hurry up because there really isn't much time left and you don't want to be 60 years old when your baby is 4. You don't want to be an aged parent. If you do have children, you want to be able physically and emotionally to share in some of the activities of the child and if you're going to be like 40 years old, you're going to be too tired to do anything. So I am feeling a kind of pressure of time going by.

When we first got married we said maybe in two years, and now it's been three years and I could easily say, Oh well, maybe in two more years. We're sort of thinking, well, maybe before I'm 30. But the longer you put it off the more you tend to.

EXPECTED FERTILITY AS A CHILDBEARING CONSIDERATION

The careful use of contraception to prevent pregnancy may be motivated by a woman's assumption that she is highly fertile. But a woman who has doubts about her fertility may be motivated to become pregnant in order to determine her ability to have children and thus allay her concerns about her fertility.

I just am certain that I can conceive. There's never been a doubt in my mind. My family is very fertile. I would be mighty shocked if I decided to get pregnant if I didn't get pregnant the very first month. That would be the shock of my life.

I kind of thought that perhaps I couldn't have children, and this is because I have an aunt who never did have a child and it's known that in my family some women are not able to have children. This was a great concern of mine. I think at the time I got pregnant, I was more or less testing myself as to whether or not I could really have children. I had this deep doubt inside of me that I just might be the one in the next generation who can't have a child.

PREGNANCY ANTICIPATIONS

How do the various anticipations pertaining to pregnancy and the meanings a woman associates with it enter into her childbearing considerations? A woman may look forward to or be curious about the experience of pregnancy, or simply view pregnancy as a natural means to a desired end. She may wish to experience pregnancy and yet not wish to have a child; or she may desire a child but dread the thought of pregnancy. She may be concerned about the possible discomforts during pregnancy or the limitations on her activities that a pregnancy would require. She may view pregnancy as an enhancement of a woman's attractiveness or as a temporary or permanent disfigurement that will make her less attractive to her husband. She may look forward to the social approval or special attentions and considerations that she expects to receive while pregnant, or she may anticipate feelings of shame or embarrassment from the attention a pregnancy would elicit, since it would reveal that she has engaged in sexual activity.

I have a great curiosity to know what it is like to be pregnant. It just seems like it's a completely different state. I'd like to ex-

perience being pregnant to see what the thing is like.

I accepted that if you're going to have a child, you have to be pregnant. If you could have a child without it, well, more power to you, but it's impossible. I never thought of it in terms of how bad you look or how good you look. Obviously, you don't look your most gorgeous with your stomach sticking out like that. But the end justifies the means.

I am curious to know the feeling of life. I would be interested in becoming pregnant, if childbirth were the point at which pregnancy ended.

It can't be very nice to make love to a pregnant woman I wouldn't think. It's hard to imagine because you've got the big bump in the middle and you can't look attractive, I mean, your shape doesn't look attractive and I'm sure it will affect my husband. He'll feel funny anyway.

To tell people I'm pregnant, then it's like they know; but since they knew you were married, they must know what you're doing. But when you show the whole world what you've done, it's different.

CHILDBIRTH ANTICIPATIONS

Labor and delivery may be anticipated as a normal or natural experience, even as a potentially exciting one. It may be viewed as a painful means to achieve a highly desired end, or anticipated as a terrifying and unbearable experience. A woman may experience an intense childbearing conflict because of her fear of bleeding, injury, mutilation, or even death at delivery.

Yes, I am wondering if it would be hard. Sometimes I think that when I have my period and I have cramps, would this be almost the same feeling, and then I feel you're having it for a reason. It's the reason why you're going through pains of birth and when you know it's for a particular reason I guess your body can stand something like that.

I have two feelings. One, that I have this fear that the pain would become so unbearable that I would lose control. The other part is that I would enjoy the entire experience. I even have at times a feeling that it would

be a good experience, an exciting experience, a partly sexual experience, an entirely total experience. One part of me doesn't think I would have any difficulty either giving birth or having a fairly natural pregnancy. There seems to be another part, where I have all these terrors and all these fears.

It is a state where you're like an animal, like a cat having kittens or a dog having puppies, you're an animal reproducing and at that particular time you are just no more a human, you're just another animal. I imagine it is very messy, and painful, and uncomfortable, and very undignified in a way.

FANTASIES PERTAINING TO THE NEWBORN INFANT

Fantasies pertaining to a newborn infant may be a source of childbearing conflict. One woman may assume that she will give birth to a healthy, normal child, while another may have fantasies of giving birth to a child which is physically or mentally abnormal or defective.

Thinking about the horror with which a mother must face a baby that's deformed seems to have contributed to my desire not to become pregnant; there might be some deformity or something radically wrong with the infant.

I was just thinking, a women gets pregnant, she's going to have a baby, she could have some kind of child that wasn't even human.

SUMMARY

The concept "childbearing motivations and conflicts" provides a psychosocial framework and an integrative focus for the investigation of differential family size preferences, child-spacing intentions, reactions during successive stages of the female reproductive process, and patterns of maternal behavior. The paradigm presented here for the analysis of childbearing motivations and conflicts of married women prior to the birth of the first child consists of a set of perspectives for eliciting and classifying

the multiplicity of diverse meanings that may motivate a woman for childbearing or induce a childbearing conflict. The perspectives schematized for delineating the motivational considerations pertaining to childbearing are: (1) Social expectation of childbearing and motherhood. (2) Childbearing among peers. (3) Identity implications of childbearing and motherhood. (4) Identification with a fantasied child. (5) Childhood memories of family life experiences and identification with own mother. (6) Childrearing anticipations and expected relationship with children. (7) Marital context of childbearing. (8) Relationship with own parents as a childbearing consideration. (9) Age and years childless as a childbearing consideration. (10) Expected fertility as a childbearing consideration. (11) Pregnancy anticipations. (12) Childbirth anticipations. (13) Fantasies pertaining to the newborn infant. The delineation of these individually listed but interrelated analytical perspectives is a step toward constructing a typology of childbearing motivations and conflicts.

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PROGRAMED LEARNING, TEACHING MACHINES, AND DYSLEXIA

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Teaching machines and programed learning are becoming increasing prevalent in our school systems as educators attempt to improve the quality of instruction. There is, however, an alarming lack of scientific evaluation of these procedures for many reasons. This review argues that programed methods have not been carefully evaluated by controlled studies and suggests that in many instances we are subjecting students to unproved procedures.

The clinician concerned with psychopathology is confronted with a dizzying array of technological advances in those disciplines concerned with behavioral modification. To mention but a few: psychopharmacology has offered an ever-increasing number of psychoactive agents; experimental psychology has produced powerful tools for altering and restructuring human behavior^{6, 40}; the more recent techniques in neurophysiology and neurosurgery allow the probing and alteration of human affect.^{10, 18} Our concern in this paper is with an area, educational technology, which is becoming increasingly—indeed exponentially—relevant to the problem

of services for the psychiatrically ill and which will require careful consideration with respect to its therapeutic value.

With the augmentation of technological sophistication, facilitated by the relatively new discipline of systems theory, a spectacular burgeoning of computerized teaching machines has occurred, with a resultant profit-motivated liaison between the electronic industry and book publishers.* Through advertising, educators and educational systems are actively being enticed into purchasing these products in spite of the warnings of even the most zealous paladins^{32, 87} concerning the present level of usefulness of automated and programed learn-

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* Amongst mergers to date between book publishers and electronic companies are those of Edison with McGraw-Hill; CBS with Holt, Rinehart and Winston; Random House with RCA; Ginn and Company with Xerox; and Grosset and Dunlap with National General Corporation.

ing materials. The economic magnitude of this issue has been expressed in the Congressional report *Automation and Technology in Education*,² where it was stated that "The American economy was built around the railroads in the last half of the 19th century, around the automobile the first two-thirds of this century, and it will be built around education in the balance of this century." This statement serves to emphasize the scope of the educational-industrial complex and it is well for the physician to bear this in mind, for the developments in this area have immediate implications for the increasingly larger number of patients under our care who require educational remediation.*

Specifically the plan of presentation will be as follows: First, some definitions pertinent to an understanding of programmed methods will be offered, followed by a discussion of the status of the empirical basis of programing. Problems in program assessment will then be presented along with the findings of some controlled studies on the effectiveness of programing in the acquisition of reading skills.

PROGRAMED LEARNING AND TEACHING MACHINES

An instructional program has been variously defined by those working in educational research, and, as might be anticipated, some disagreement exists. One frequently cited definition²⁴ states that a program "is a vehicle which gen-

erates an essentially reproducible sequence of instructional events and accepts responsibility for efficiently accomplishing a specified change from a given range of initial completeness or behavioral tendencies." The key words in this definition are reproducibility, sequence, and efficiency, for as will be seen these comprise after some qualification the suggested criteria for program assessment.

The sequential instructional events mentioned in the definition are referred to as frames. The probability of a student selecting the correct response to a given frame may be facilitated by incorporating clues into the content of the frame. These clues are called either "cues" when they are within the context of the frame or "prompts" when they precede the frame. This is a rarely used distinction, and cuing and prompting tend to be used interchangeably.

After responding to a frame the student is immediately notified whether his answer is correct or not. This factor plus the design of programs so that the error rate is small (10% or less according to Holland) is said to be reinforcing when it facilitates retention of the material learned and increases the likelihood of the student continuing to select the correct response.

A constructed response program may be arranged to present frames in one of two ways, linear or branched. A linear program involves a succession of instructional events without omitting

* The potential magnitude of this problem was recently reviewed for the profession by the Surgeon General of the U. S. Public Health Service.²⁵ By 1980 there will be 76 million children under 15. Perhaps 20% to 40% of these children will suffer from one or more chronic diseases. If the medical professional accepts the principle that children should be seen regularly by a physician, Dr. Stewart asks, "Do we dare create a demand for this service? What would we do if we were successful?" Although no figure was offered, we can anticipate that a considerable number of these children will have organic learning deficits for whom the services of a neuropsychiatrist will be needed.

Figure 1
EXAMPLE OF A CONSTRUCTED RESPONSE PROGRAM

VISUAL STIMULUS	AUDITORY STIMULUS	RESPONSE	FEEDBACK
M	This letter makes the sound "M." You say "M."	"M"	(none)
M	What sound does this letter make?	"M"	It's "M"
S	This letter makes the sound "S." You say "S."	"S"	(none)
S	What sound does this letter make?	"S"	It's "S"
M	Does this letter make the sound "M" or "S"?	"M"	It's "M"
M	Say the sound.	"M"	"M"
S	Does this letter make the sound "M" or "S"?	"S"	"S"
S	Say the sound.	"S"	"S"

Note that each frame builds sequentially so that the student is required to understand the previous frame before he can proceed with subsequent correct identifications. A branched program would provide supplementary frames to ensure the student's understanding should he make an incorrect choice. It would then lead back into the program.

any items, while a branching program allows the student to strengthen areas of insufficient knowledge by providing miniature programs for certain frames. Programs may also be of multiple choice construction. In this form the emphasis remains on immediate awareness of errors; however, the error rate is not felt to be as crucial as in constructed response programs. Multiple choice programs are not as widely used as constructed response programs.

Once devised, a program may be automated for use on a multitude of machines or presented in booklet form. Teaching machines are of many varieties but in essence involve the use of automated means of presenting the student with the next frame, following a response, in an instructional series. The more sophisticated machines can pre-

sent instructional material addressed to many perceptual modes (auditory, visual, tactile) either alone or in combination. The presentation of frames can also be accomplished by nonautomated booklet presentation in which a student makes a response and then discovers the nature of his answer by turning the page or moving a slider. Booklet programs may be supplemented by audiovisual aids (slide projectors, tape recorders, etc.). The use of computers to record the student's response and present him with the appropriate frame now forms the basis of large computer-assisted instruction units at Stanford, Pittsburgh, and Harvard, and more installations of this type may be anticipated.¹ Regardless of the complexity of the unit, its function remains that of presenting the student with the next

frame in a predetermined sequence, and selecting this frame on the basis of the student's previous response.

Of the many auto-instructional devices the Edison Responsive Environment (ERE) is of particular interest since it is claimed that it has psychotherapeutic value for certain clinical syndromes, including autism.¹⁵ This advantage claimed for the ERE rests on the "responsive environment" learning theory of O. K. Moore.²⁹ An environment is said to be responsive if it informs the subject immediately about the consequences of his actions, permits him to exploit his capacity for discovery, and is so constructed that discoveries about the world are interconnected, be they physical, cultural or social. No controlled study has demonstrated either the superiority of the ERE over other auto-instructional devices or of any specific psychotherapeutic effects.

IS PROGRAMING A SCIENCE?

One of the advantages claimed for programing is that it is based on empirically established principles. A number of authors have reviewed this assertion^{11, 13, 19, 20} with varying degrees of agreement. Holland³⁴ enumerates five scientific principles pertaining to programs which he feels have generally been experimentally supported. These are: (1) a contingent relationship between answer and content; (2) the ability for the contingency to be met (low error rate); (3) sequencing for materials that build sequentially; (4) a range of examples for full comprehension; and (5) for long programs, a public response. Holland finds fault with some studies which do not support his conclusions on the basis that they do not satisfy the criteria posited for

programed materials, e.g., low error rate or demonstrated effectiveness of the program. On the other hand Deterline⁸ has indicated that programs can be constructed with a much higher error rate than previously maintained and without interfering with the program's effectiveness. He feels that attention should best be directed towards dealing with the individual student's responses and progress rather than on percentages of mean error rate as Holland argues.

Of those studies and reviews which investigate the scientific principles underlying programing, a few can be mentioned briefly. In an effort to investigate the importance of prompting and confirmation in teaching words to mentally retarded subjects, Blackman⁴ found that prompting did not facilitate performance; however, he questions the adequacy of the program used. Swets,³⁹ in an attempt to teach the discrimination of nonverbal sounds to patients with auditory discrimination deficits, found no support for the hypothesis that learning efficiency is directly related to the probability of reinforcement. A number of studies considered by Gagne¹² led him to conclude that "few relationships have been demonstrated between independent variables in effect during the learning period and later retention scores." The lack of support for a relationship between post-test performance as a function of confirmation or immediacy of reinforcement is also accepted by Holland. It should be noted that this is one of the most fundamental concepts in the application of learning theory to constructed response programing. Moreover, Fry¹¹ has stated, in regard to the empirical basis for programing, that it is "long on learning theory rationalizations . . . but relatively short on hard

core data;" and Hilgard¹⁹ that "advances made in programed learning have been based very little upon a strict application of learning theory regardless of what devotees of the different theories may assert."

The problems in adequately applying learning theory principles to educational technology comprise the major burden of those working in that discipline. At least some have acknowledged their present limitations and future responsibilities. In the area of reading acquisition, for example, Silberman³⁶ has stated "It remains for future researchers to develop a reading program with a synthetic sequence established on dimensions of grapheme/phoneme correspondence, word frequency, meaningfulness, syntactic structure, language redundancy, and stimulus similarity, all of which have been shown to influence learning efficiency." In the same vein, Lumsdaine²⁴ comments, "A great deal more evidence than is now available is necessary before a well developed science or validated theory of programing, on the basis of which program effectiveness can be reliably predicted, can be delineated." It would seem that an empirically validated product is not yet available for public consumption.

ASSESSING THE EFFECTIVENESS OF PROGRAMED INSTRUCTION

Skinner in an interview reported in *The New York Times* stated with disdain that there was as much necessity to control for programed and automated instruction as there was to control for the handwashing of clothes as against a washing machine. This argument rests wholly on the criterion of convenience. Had the criterion been cleanliness, an empirical question could have been pre-

sented for testing. Since so much is expected from programing, it seems only reasonable that some criteria be available to allow us to determine whether it can satisfy the tasks which are being assigned it. There are no means of accomplishing this other than by comparing its effectiveness with other means of reaching the same objective, i.e. by controlled experimental studies.

Another and related means of assessing instructional efficacy is that of cost analysis. In this regard, the Subcommittee on Economic Progress² has indicated that the amortized costs of computer instructional equipment should not exceed 25 cents per student hour in elementary schools and 50 cents per student hour for special education. Those cost analyses known to the author indicate that computer-assisted instructional programs greatly exceed this suggested figure. Green¹⁶ has indicated the consequences of the field's lack of concern for controlled studies: "Certainly, few at this stage would be willing to accept the responsibility of doing consumer research on programed materials. The complexities of procedure, the general inadequacies of experimental control, to say nothing of the confusion of the logic of test theory as applied to programed instruction, would deter all but the most courageous or the most naive from such a task." This is an alarming statement when one considers the many millions of dollars spent annually by consumers of those products, the effectiveness of which only the courageous or naive can question.

In spite of the bleak picture this would suggest, rigid standards for program assessment have been offered, however poorly or rarely used. Markle,²⁶ for one, has indicated three phases of

program development: (1) the development phase, (2) the validation testing phase, and (3) the field testing phase, and suggested ways in which they can be assessed. The lack of information relative to the assessment of program materials is blamed by her, at least partially, on the expense of such investigations (hence she implies one can forgive the profit-motivated manufacturers) and on the indifference of the consumer who has failed to apply "pressure." This tendency to place the responsibility for the use of unvalidated programs on the consumer is also apparent in the AERA-APA-DAVI²¹ committee report. "The effectiveness of self-instructional program can be assessed by finding out what students actually learn and remember from the program. The prospective purchaser should find out whether such data are available and under what conditions the data were obtained." If, as Markle has pointed out, we cannot rely on the manufacturer or the purchaser, and the programmers have for the most part ignored the criteria suggested for assessing program development, then the situation is sorry indeed. The ones most likely to suffer would appear to be the prospective student and the taxpayer.

PROGRAMED INSTRUCTION AND CONTROLLED STUDIES

Controlled studies have failed to demonstrate any clear superiority of programing over traditional classroom methods. Consider the problem of whether students of low or high intellectual ability will benefit most from programing. Reed,³³ for example, found that low-ability students perform better following traditional presentation than for programed presentation, while a study by Porter³¹ indicated that children

in the lower ability range did better with programed as against conventional instruction. McNeil²⁷ reported that children in the lower ability range derived more benefit from programs than conventional instruction in reading, while Gropper¹⁷ reported that better students were helped more with programing. The different ages of the students, social class of the subjects being taught, and a multitude of other uncontrolled variables makes it impossible to conclude from these studies who, and under what conditions, will learn which best. Moreover, in a review of a number of controlled studies which claim greater efficacy for programing over usual classroom procedures, Leib²² cautions the reader against drawing conclusions because of deficiencies in study design, foremost of which is a failure to control for actual study time. In a paragraph which indicates nine questions which Leib et al. feel need further research, is included: "Is there a difference in retention for programed instruction resulting in greater achievement, less time spent in study or both?" The very basis of assessing the efficacy of the approach is, in Leib's opinion, not established.

To compound difficulties it would appear that a program devised for one form of presentation, e.g. booklet, may produce different results when it is automated. Silberman³⁵ found this to be the case when comparing response characteristics on a fixed sequence vs. a branching program, using textbook presentation vs. computer-assisted presentation. On the other hand, Goldstein and Gotkin¹⁴ reviewed the findings of eight studies comparing the presentation of the same material by booklet programs vs. automated techniques. They found no superiority of one presentation mode

over another as measured by mastery over the material. A time savings was found in some instances for the much cheaper booklet presentation. Silberman's study, although not directly comparable to those reported by Goldstein and Gotkin, does, however, justify questioning whether individual programs devised in booklet form are immediately translatable to automated techniques. It seems clear that data on both should be available. It is of interest that the Sullivan programed series for beginning reading devised for booklet presentation is being translated for use with the Edison Talking Typewriter although no normative data on error rate, retention or motivational characteristics of the program could be supplied by the manufacturer. On the other hand an automated program developed on the Edison Responsive Environment machine for teaching reading to culturally disadvantaged children²⁸ is reported to be just as effective in booklet form, which raises serious doubts about the actual necessity for the very expensive machine.

CONTROLLED STUDIES ON BEGINNING READING

Most studies attempting to compare programing or automation to traditional classroom methods in teaching reading have found little difference between them. Blackman⁴ compared reading and arithmetic achievement of retarded adolescents using automated programs vs. traditional classroom methods. No superiority was evidenced for the teaching machine group other than improvement in deportment which, although appreciated, was not the primary objective.

Blatt⁶ was unable to demonstrate any superiority of a machine-enriched environment over an otherwise enriched en-

vironment or of these two over no intervention at all for culturally deprived preschool students.

Rudell³⁴ compared the Buchanan programed reading series vs. the Sheldon basic readers. He assessed student progress on the Stanford Achievement Test Subtests—paragraph meaning, word reading, spelling, and study skills. There was no essential difference on any of the subtests other than higher scores for the Buchanan series on a test for recognition of phonetically constructed words read orally. Since the Buchanan program is linguistically constructed, this difference is to be expected.

Liddle²⁸ assessed the efficacy of the Sullivan series vs. ordinary classroom instruction. Children were evaluated with the Metropolitan Readiness Test and post-test measures of word knowledge, discrimination, and reading level using the Metropolitan Achievement Primary I. This study, conducted under the auspices of the publisher, is inadequate from many perspectives: IQ was not controlled, nor were data given to indicate the pre-test scores of the groups. The author does state, however, that the experimental group had a slightly higher score on the pre-test measures. In spite of the inadequacies inherent in this study, the initial hypothesis, that there would be no difference between the two groups, was corroborated.

Malpass²⁵ reported on two automated and one traditionally taught classroom group controlling for sex, chronological age, mental age, programed words known, reading test score, length of schooling, health, and socioeconomic status. Students were randomly assigned into groups. Although some differences were found in immediate test measures, 30 days following intervention there

were no significant differences between the automated and traditionally taught groups.

Pont³⁰ investigated the effectiveness of the Sullivan series for teaching beginning reading controlling for intelligence and reading quotient scores. No differences were noted either in the period during the procedure or seven months following the experiment in the two groups.

Contrary to these, a recent study by Ellson⁹ which controls for tutorial time offers evidence that two programmed sessions per day produced markedly greater gains for poor readers than traditional methods of directed tutoring. Challs⁷ exhaustive study on reading methods led her to conclude that no specific code emphasis approach (phonic or linguistic) was superior to any other code approach but that the code approach was superior to the now prevalent look-say or whole word recognition method. As a consequence of her findings she recommends major changes in teaching method. The eventual effectiveness of a systematic code emphasis approach for teaching remedial reading remains to be established by empirical investigations.

CONCLUSION

The factors involved in assessing the dyslexic child's impairments are numerous and involve the participation of many specialists. We might anticipate that the educational psychologist will soon be joining the social worker and physician in remedial efforts. It is well to be familiar with the deficiencies of his efforts as it is to be familiar with our own and it is to this end that this review has been addressed.

The use of teaching machines and

programed instruction in providing the best educational opportunities possible for these students is potentially too promising to be lost by default. The lack of adequately trained teachers, facilities, and opportunities for rehabilitation is a well-known void which a properly conceptualized and implemented science of educational programing might reasonably be expected to fill. Caution, however, is necessary. An awareness of the inadequacies of traditional methods of education, the vacuous quality of our instructional material, and the limitations placed on students by present educational methods is disquieting. If programs which compete with traditional techniques can do no better, then the situation is serious indeed. Nothing short of a complete renovation of the educational system, with high standards of teaching competence and student performance, will suffice. Considering the priorities of governmental expenditure and the recent meager allotment relative to need for education, this is not likely to occur without massive social pressure and reallocation of priorities and resources.

It is entirely possible, if not inevitable, should we not take heed, that programmed materials and automation will work in such a way as to maintain the mediocrity of our educational system, which is to say that if it does not offer something radically better, it has not offered anything at all but profit and control by a growing educational-industrial complex.

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LSD SUBCULTURES: ACIDOXY VERSUS ORTHODOXY

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Participant observation and interviews in San Francisco, New York, and London make it possible to present some of the distinguishing characteristics of the LSD and therapy subcultures. Characteristics discussed are: subcultural differentiation, status, relevant experience, sex, and religion. The relative utility of the (old) anxiety and the (new) alienation model is tested. The author suggests that new therapeutic values and strategies will be needed to "treat" LSD users.

There is no need to document what everyone knows—that there are a lot of young people whose special use of psychedelic substances is part of their special relation to contemporary culture. The special set of values, attitudes, and opinions of this LSD subculture were the focus of my participant observations in London, New York, and San Francisco during the past three years. "Interviews" with hundreds of users revealed that an acid subculture is comparably to be found in many other world cities, e.g. Copenhagen, Jerusalem, Tokyo, Paris, Berlin.

Less well known is the fact that there is a growing tension between the subculture of LSD users and what might be called the subculture of therapists. The following paragraphs describe some aspects of this tension, written as much to solicit as to share insight into a phenomenon which increasingly troubles professionals in the therapeutic community.

VALUE CONFLICTS

In addition to their use of psychedelic substances which precipitate experiences of a sort radically different from those

This paper is a modified version of one presented at the 1968 annual meeting of the American Orthopsychiatric Association. The rapidly changing nature of the youth scene makes it advisable to regard the paper in an historical perspective.

with which the midrange of therapeutic personnel are familiar, hippies (and yuppies and many others) are outspokenly antifamilial (dropouts), antipsychiatric (pro-paranoid), and antibureaucracy (radical politics). They deplore wealth as alienating (the Digger Free Store), cleanliness as neuroticism (clean is a hang-up), and prefer free sex (group grope) to the marital practices sanctioned by society. They refuse the counsel of rationality (the bomb is rational; the Pentagon is rational) and they insist that "doing my thing" is healthier and saner than going to war or programing computers. They regard the "trip" as a unique experience, communes as better than traditional family life, and look forward to the replacement of "violence" with "love," and "education" with "ecstasy."

They are increasingly regarded as social pariahs, public health menaces, political pests, and as a degenerate generation, labels which are said to earn them the right to "treatment." Yet, treatment programs face a number of very practical problems, in addition to the value differences described above, when they try to offer service to this population. Few are willing to become patients voluntarily. Even if a given therapist has attempted to manage his countertransferences to a patient who regards him as ignorant of the trip experience, biased in favor of family life, militaristic because he offers therapy instead of politics, an impersonal bureaucrat because he is an agent of an agency, "hung-up on loot" because he works for a living, and a puritan because he's clean and (relatively) monagamous and heterosexual, a therapist must still confront a

number of perplexing problems. For example, in attempting to cope with a patient experiencing a bad trip which may last for 10 or 12 hours, what is to be done about scheduling? When the patient is a 16-year-old who has run away from home and does not wish to speak to his or her parents, of what use is family therapy? Or, if one wants to treat the natural group (or social network)* of significant others, does one suggest that the whole commune come in? Is a bad trip an "emergency?" Does Thorazine mollify a bad trip? Does Niacinamide?

Faced with these kinds of questions, an increasing number of therapists are reexamining their treatment rationales, so that convictions developed over long years of experience are now sometimes regarded as value assumptions which may require modification.

In our interviews we explored five areas. We did not structure the interviews, so that often other areas cropped up to the exclusion of our principal concerns. If we could comfortably squeeze a question in, we did. If we couldn't, we didn't. Our interests were:

1. *Subcultural differentiation*: we wanted to know what trippers and therapists thought of each other.
2. *Status*: we wanted to know whether the avant-garde nature of the acid scene threatened orthodox therapists.
3. *Relevant experience*: we wanted to know whether the trip is a unique experience.
4. *Sex*: we wanted to know if traditional family sex and trip sex differed.
5. *Religion*: we wanted to know whether tripping involved religious experiences.

* I use the term in the sense conveyed by Dr. Ross Speck's work.

SUBCULTURAL DIFFERENTIATION

With respect to subcultural differentiation, we found a continuum of attitudes which rendered our dichotomy of trippers versus therapists useless. Although we spoke with trippers who regard therapists who have not "dropped" acid as hopelessly out of it, we also spoke with trippers in therapy with nonusing therapists who felt that the course of therapy contained learning experiences for both parties. However, trippers whose therapists had had an LSD experience were uniformly envied by trippers whose therapists had not.*

Self-administered massive dosages may result in good or bad trips. Good trips induced in this way will ordinarily not send a tripper to a therapist. Bad trips might, if the tripper panics and has no one else to "talk him down." The acid-experienced therapist will know how to talk his patient down, if he has a number of hours available. The acid-inexperienced therapist usually doesn't know that a patient in a bad trip *can* be talked down, and may resort to medication (Thorazine, Niacinamide). When he does, in the words of one respondent, "Then you have *both* the Thorazine *and* the bum trip to handle." A particular danger is the possibility that the bad trip is due not to LSD but to STP, for the combination of STP and Thorazine is believed to be fatal. The role of the inexperienced therapist who fails to make this crucial distinction is not an enviable one.

It is not surprising, therefore, that therapists who have had relevant experi-

ences are preferred by trippers. Like the heroin addicts of yesteryear,² acid "heads" know that there is no sure way of knowing the strength of a "cap" of acid when they buy it (or are given it free). Nor is it surprising that trippers feel confined to their own resources and not a little disdainful of the therapist subculture, which, by and large, but especially in the United States, is an acid-inexperienced subculture.

Perhaps the most important finding which emerged from our interviews is the fact that the experienced trippers regard inexperienced trippers who seek the help of acid-inexperienced therapists as fools because of the high likelihood that acid-inexperienced therapists are not only not *able* to help but are not *willing* to help, due as much to their alleged moralistic alliance with an anti-acid society as to their fear that acid is better than analysis (a fear expressed to us by a number of therapists). More often, therapists said that they'd like to try some but legal concerns prevented them. A few therapists said they were able to learn a good deal about LSD from patients who began treatment with them before they began experimenting with LSD, but that they feel limited in their ability to empathize with the experience.

It should be noted that many of the interviewed protagonists of the LSD experience, both trippers and therapists, do not regard the experience as fitting in neatly with psychoanalytic paradigms, so that, in their view, LSD should not be regarded simply either as a defense

* Here it is necessary to distinguish, as Leuner⁷ does, between psychedelic therapy, which involves massive doses of LSD in one or two breakthrough sessions, and psycholytic therapy, which involves repeated lower dosages at regular intervals as adjuncts to the therapeutic process. It is additionally necessary to distinguish the self-administered from the professionally administered trip, since they may differ markedly in the experiences thereby engendered.

dissolver or as an ego builder, because such views are uncomfortably psychologicistic. The social nature of the experience has also been noted by many investigators, notably by Becker¹ and Cheek,³ who have shown that social groups selectively define aspects of the drug experience as real and unreal. Our respondents repeatedly referred to the sociopolitical dimensions of the experience, reminding us, in the words of one young girl, that "dropping acid and dropping out are really very similar, because, you know, in an insane world, counterinsanity is saner than plain insanity." Thus, many users inquire more deeply into the therapist's political views than into his therapeutic credo, often believing them to be more intimately related than the therapist himself does. We have interviewed therapists who do this to patients.

STATUS

With regard to the relative status of the acid subculture, a number of conclusions emerged from our interviews. First, as reported above, many therapists felt that sooner or later they would have to learn more about the LSD experience since they believed the number of users to be increasing and expected them to need help eventually. Some therapists thought that they would eventually try it, and others (usually the younger ones) eagerly looked forward to the experience.

A paradoxical finding is the following. Before acid, therapists who preferred the organic viewpoint to the psychogenic one were regarded by many as old-fashioned. Some smiled knowingly at those who did not employ the then-fashionable terms derived from psychoanalytic theory. Now, the shoe seems to

be on the other foot. Those who attempt to reduce the acid-induced experience to psychoanalytic terms are regarded as conservatives resisting the new orthodoxy. Terms like "synaesthesia" are in; interpretations like "identifying with the object" are out, at least among those we interviewed. This should not be taken to mean that psychoanalytic investigators are not researching the acid scene. Dr. Dahlberg at the William Alanson White Institute in New York is among those highly regarded, although he is seen as cautious in both method and dosage levels.¹⁰

Some who resort to LSD find their particular pathologies temporarily masked or even alleviated by the experience, but acid is no leveler. In fact, the contrary seems often true, which is recognized by experienced users in their ability to distinguish what is generically due to acid and what is specifically due to idiosyncracies of the individual. Again, we found our initial dichotomy to be naive. The question is not whether acid dethrones orthodox diagnostic categories; the real question seems to be which personality types respond to acid in which ways. The work of Linton and Lang⁸ is particularly instructive in this regard, as is the work of Blum² and his associates. They find different personality patterns at varying dosage levels.

It should be noted that psycholytic therapy is gaining in popularity in Europe as a professionally administered modality. In the United States, in the absence of legal availability, it must be reported that self-administered massive dosages are on the increase, especially now that incidents of chromosome damage have been reported, then contradicted, then re-reported, so that even professionals in touch with the literature

state that the controversy has not yet been resolved.⁴

The status of the LSD subculture is in rapid flux. Hippies in the East Village, in the Haight, in Soho are now avoiding the harsh glare of publicity because they know that publicity, for them, leads to ridicule and persecution. They resent the commercialization of their way of life, their music, and their art, because it serves as a vehicle for cheap imitation by faddists. Nor do they wish to be put in the mobility race and competed with for status. Many of our respondents were very seriously concerned with freedom, both inner and outer, and would be much happier if they weren't cast in the role of criminal violators of the American way of life; bucolic emigration for those who are is becoming increasingly attractive.

RELEVANT EXPERIENCE

From the point of view of relevant experience there is almost uniform agreement—the trip is unique. This is not to say that LSD is the only psychedelic drug, for there are many of these. Mescaline and Peyote are favorites, as are Psilocybin and Psilocin. Other psychedelics have been in use for centuries, but they are not ordinarily found in the training experiences of therapists, and there are few if any comparable experiences in the orthodox psychoanalytic encounter. Alcohol is simply not comparable, nor are the tranquilizers, sedatives, depressants, and stimulants found in the psychiatric arsenal. William James' famous experience with nitrous oxide (laughing gas) is well known and his reaction was very much his own. Others find this chemical quite delightful. One of our respondents *prefers* it to LSD. But acid, like sex, is hard to compare with other experiences.

SEX

In a much quoted interview in *Playboy*, Timothy Leary stated that the real secret behind the acid scene was LSD's fantastic aphrodisiacal properties, which, for example, enabled women to have "hundreds" of orgasms during a trip. If one takes the term orgasm literally (that is, biologically), our respondents contradict Leary's assertions. However, if one takes a more metaphorical meaning, our respondents indicate that the statement is true, by which they seem to mean that moment after moment is filled with delights of the most sensuous and rapturous sort, and that, for hours on end, in what seem to be vastly extended spans of time, wholly satisfying releases of ecstatic bliss are attained with magnificent ease.

It has been claimed that LSD is not specifically aphrodisiacal but has that effect because it heightens the exquisiteness of perception across the entire sensorium, so that, if sex is what one is experiencing, it is a heightened and exquisitized sex one will experience under LSD. Our respondents told us that there were three ways in which LSD "heightened" the sexual experience: (1) It dissolves defensiveness and anxiety, thus enabling one to enter fully into the experience. (2) It extends the sensations associated with sex so that stroking and orgasm are spread over large regions of the body. (3) It extends experienced time (as opposed to clock time) so that one seems to have more time in which to "luxuriate." Thus, even though the clock is running, one can play at one's own pace. "Since a short time seems to last a long time, it's better," is the way one of our respondents put it.

We were also specifically interested in another aspect of psychedelic sexual

behavior, namely, what one of our respondents called the "group grope" in which a number of individuals of both sexes participate in what might be termed an orgy. We were told that group sex does *not* derive its impetus mainly from LSD but from the political rejection of the notion of private property and from the practical unattainability of privacy in the urban commune—that acid only served to disinhibit those who *already* had the wish to "love together."

It is instructive to observe that psychededic sex differs markedly, however, from narcotically disinhibited sexuality, since the latter becomes increasingly impossible as dosages climb. Hence, a sharp distinction should be drawn between the psychedelic sex, which is improved, and narcotic sex, which is depressed. Nevertheless, LSD users said that group sex is part of the new political philosophy of community with which they are attempting to replace older political philosophies of proprietary (commodity) sexuality. Actually, we were told that acid and group sex, in combination, are *both* aspects of a new political philosophy which is emerging in the youthful acid subcultures around the globe, and that proper initiation into this subculture involves far more than acid and group sex.

Of interest to us was the relation between the "communes" in which group sex is often practiced and the "family processes" characteristic of the more permanent of these communes. If, for example, a certain girl functioned as the mother of a given commune, did she also function as a group sex partner? If so, what about incest taboos, and if not, why not? We were told that roles were frequently reallocated within communes, so that this month's mother might be next month's daughter, etc.,

and that there were major differences to be found among rural versus urban communes, the latter experiencing a more rapid change of personnel. We were further informed that group sex was *not* the rule but was not precluded by rule either, so that, if the spirit happened to move them on any given occasion, it might occur. The fact is that dyadic pairings are by far the more common occurrence. We were repeatedly told that LSD was not the *sine qua non* of group sexuality. One of our informants reminded us that several accounts existed in anthropological literature describing similar practices among adolescents in preliterate societies, and that "drugs weren't prerequisites there either."

Hypothesizing that there might be some relation between the antifamilial values of the LSD subculture and anti-conformist sex roles, we asked dropout users whether they were consciously and deliberately engaging in sexual behaviors that were specifically opposite to the kinds of sex practiced in their families of orientation. Again, we were given responses which accused us of psychologistic reductionism, suggesting that we were hopelessly out of touch with the *generational* nature of contemporary youthful rebellion, which did *not* consist exclusively or even principally of an antifamilial revolt but of a rebellion against *all* the major institutions of urban-industrial societies. We were politely informed that it was not simply with the family that youth was unhappy, but with schools, jobs, wars, governments, businesses, and bureaucracies, indeed, the whole complex of cultural institutions of which urban-industrial societies are comprised. "This," we were forcibly reminded, "is a *cultural* revolution, not simply an antifamily experi-

ment." In this way, our hypothesis of reaction-formation received its demise. We concluded that the acid subculture may *not* solely be understood in psychological terms and that newer models for its comprehension need to be devised.

RELIGION

We have already alluded to William James' masterpiece, *The Varieties of Religious Experience*. Masters and Huston have written what may be a minor masterpiece, *The Varieties of Psychedelic Experience*,⁹ in which they address themselves to the relation of psychedelic and religious experience. Their orientation is exploratory, and they attempt to make sense out of the religious statements made by subjects who report on their LSD sessions. Some of their subjects report theistic experiences, some do not, but many report feelings which they regard as religious.

We inquired of our respondents whether they had religious experiences under LSD. Some responded that they had had experiences which they would call religious if they were religious, but they were not religious. Others said that the trip was the "most profound experience" they had ever had, and, like Masters and Huston's subjects, described the experience in aesthetic terms. Still others described the experience as one of "immense unity" and "in touch with the All." That Tibetan, Hindu, and other religious vocabularies are widely employed by LSD users is also well known. Such languages describe what Paul Tillich must have had in mind when he spoke of "ultimate concern," or what John Dewey described as a "genuine

religious experience." That such experiences were not commonly described by our respondents in theistic terms should thus not be surprising.

We were interested in the extent to which acid serves as a ritual initiation into a subculture, having investigated this hypothesis in the narcotic scene.⁵ In the present study, we wanted to know whether the "profound" nature of the LSD experience might serve as a ritual initiation into what may legitimately be termed a cult, that is, a band of believers united in common observance of religious ritual. It is difficult to classify the responses we were given to the questions we asked in this area. Some respondents pooh-poohed the idea of religious ritual, others said it was "convenient" to share a Tibetan or Hindu language. Others (a Feuerbachian proletariat?) said that what was once *called* religion is "what they were into." We regarded this latter response as the least defensively given, and found no reason to doubt its veracity.

As with narcotics, acid users almost instantly strike up a rapport with each other. It is as if there were a "community of the alienated." * For example, "heads" who read Laing's *Politics of Experience*⁶ insist that the final chapter, "The Bird of Paradise," is a trip and that Laing must have dropped some acid to write it. Thus, acid may well serve to initiate members into a mystical cult which promises deliverance from an age gone mad by suggesting that there *is* a realm of peace above and beyond the falterings of an imperfect civilization. It is not necessary that those to whom such deliverance is given also be required to have an acceptable academic theory of it.

* I am indebted for this phrase to Prof. Harry Silverstein of the New School for Social Research.

CONCLUSIONS

Our conclusions from this exploratory study are the following:

1. There is an LSD subculture. It is sharply critical of orthodox therapy, and places itself in a "paranoid" opposition to it simply because there is a uniqueness to the trip experience with which many inexperienced therapists nonetheless claim professional familiarity. Such therapists are often cast, albeit sometimes undeservedly, into the role of middle-class police whose duty it is to eliminate an allegedly monstrous drug from the scene. Not a few therapists refuse this role. Others experiment with LSD in both their private and professional lives, but they are, at present, especially in the United States, a decided minority. Those therapists who do not regard a bad trip as a moral outrage, do not quickly reach for tranquilizers when confronting a bad trip, since they see it as an experience with which they can deal empathically and, hence, effectively. Among users, professional or not, there exists a bond of empathy which many regard as a prerequisite for effective treatment, not of acid but, perhaps, even *with it*.

2. LSD-related attitudes represent in many ways only the surface of a new emergent ideology, and *therefore* enjoy the status that all new and promising things are accorded in a world in need of miracles. It may not be unlikely that in the near future the drug aspects of this ideology will be abandoned (the experience of the Beatles in this regard might have been prophetic). For, in our view, what is new about acid is not its ideology of the absolute dignity of the individual's experience, nor its conviction that love is the only sane response to a violently destructive world. What is new about acid

is its centrality to a generation of people who will not mouth beliefs they do not actually live. With this experience, hopefully, the professional therapist can feel a kinship.

3. It was Freud who taught us that sex is not always sex. The LSD subculture seems to be trying to teach us that lesson again, since we seem to have forgotten it. Perhaps polymorphous perversity is an infantile and unsociological creed. Perhaps it is a stage of development which is better transcended. But perhaps, as with play, it incarnates values which are less destructive than wars of another sort, and perhaps, for the young who occasionally experience group sex in experimental communes, it is a necessary experiment seeking new answers to old questions.

4. In an age where conscience permits the napalm flames of war to engulf civilian women and children scarcely two decades after millions were burned in ovens throughout Europe, the suspicion that terms such as "neurosis" and "psychosis" may become political weapons cannot be regarded as outrageous. Perhaps, in such an age, some of those who seek some form of ultimacy in mind-changing chemicals deserve neither to be "treated" nor to be subjected to "criminal" processes.

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RESEARCH

NEUROLOGIC FINDINGS IN CHILDREN EDUCATIONALLY DESIGNATED AS "BRAIN-DAMAGED"

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The question has been raised as to whether the designation "brain-damaged" any longer has any clinical or educational worth, since it has come to be applied to so many groups of aberrantly functioning children. The study reported here finds that children labeled "brain-damaged" do in fact have clear evidence of central nervous system abnormality, though of great neurologic heterogeneity. The usefulness of the label, therefore, may be to prevent us from attributing undue weight to the etiologic role of social environment or parental care.

Since the time Strauss,¹⁸ Werner,²¹ and their associates drew our attention to a subgrouping of mentally subnormal children whom they identified as being exogenously retarded, the designation "brain-damaged" has come to be applied to many groups of aberrantly func-

tioning children. The types of clinical entity embraced by the label have ranged from obvious cases of central nervous system damage (as in cerebral palsy) to otherwise well-functioning children who manifest behavioral disturbance or limited learning disabilities.^{6, 9} Because the

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label "brain-damaged" has come to embrace so heterogeneous an agglomeration of children, the suggestion has been made that it may well be a designation having little clinical or educational worth.^{2, 3} Modification of the designation through the attachment of the adjective "minimal"^{13, 16} or the more recent tendency to use the term "dysfunction" in place of "damage"⁷ in no way resolves the difficulty except by reduced explicitness.

However, despite frequent criticism the label has survived, and has been applied in particular to subgroupings of children requiring special educational placement. Though children so designated are found in many school systems, detailed knowledge of them is sparse. What has been particularly lacking has been a systematic evaluation of the neurologic status of children who are clinically and educationally designated as "brain-damaged," together with a careful analysis of the interrelations between their neurologic characteristics, their behavioral attributes, their intellectual level, and their characteristics as school learners.

In the series of papers of which the present report is the first, we address ourselves to this problem through the study of a defined sample of school-age children, in a suburban county, who have been diagnosed as "brain-damaged" and placed in special school assignment. In the present report we have directed our attention to the following issues: (1) the analysis of the findings on clinical neurologic examination in children who are administratively designated as "brain-damaged"; (2) the comparison of findings in these children with those obtained in the examination of like-aged children who are in regular school place-

ment; and (3) the relation of abnormal neurologic organization to hyperkinetic behavioral disturbances within the "brain-damaged" group.

SUBJECTS

The subjects of the present investigation were 105 children. Ninety of these children, who ranged in age from 10 to 12 years, attended a special educational facility for the brain-injured. The remaining 15, five at each age level, were in normal school placement and served as controls.

The admission requirements of the school for the brain-injured, which draws its pupils from an entire suburban county, include a history of educational failure and/or maladjustment as well as independent medical confirmation of the presence of brain injury. After referral, which is initiated by the local educational authorities, the school conducts its own educational, psychological, and social evaluation directed towards determining whether the child's best interests will be served in this particular school placement. These procedures result in the rejection of children who are grossly psychotic or who have other severe emotional problems, as well as those for whom suitable educational opportunities are found to exist within their neighborhood schools.

The school is attended by children who derive primarily from upper-working-class or lower-middle-class backgrounds. Of particular note is the marked underrepresentation of children from especially deprived social backgrounds. The student body ranges in age from 6 to 20 years with each age level represented by between 40 to 50 children. The study sample was randomly selected by age to include 30 children at each

age level between 10 and 12 years, and thus closely approximates the total school population within this age range.

Among the subjects were 70 boys and 20 girls. The male-female ratios were insignificantly different at each age level. Included among the subjects were eight Negro children, and one child who was of Puerto Rican descent.

The 15 control children, who attended a regular educational facility in the neighborhood, were insignificantly different from the subjects with respect to age, sex, social class, and ethnic origin.

METHODS

Each child was neurologically examined during regular school hours in a specially designated area within the school. Interspersed among the "brain-damaged" subjects were the 15 children who attended a nearby regular school facility and who served as controls. Whether a child came from one or the other facility was unknown to the examiner.

Neurologic evaluation was restricted to findings of clinical examination. The examination included the study of cranial nerve intactness, reflex organization and the presence of pathological reflexes, muscle strength and tone, balance and gait, motor coordination and sensory organization.

In addition to these measures the examination included procedures designed to provide information about responses to double simultaneous tactile stimulation, the presence or absence of adventitious motor overflow, the ability to engage in imitative motor activity, as well as clinical assessment of speech and language functions, and behavioral organization.

Responses to double simultaneous

tactile stimulation were evaluated in accordance with the criteria established by Bender, Fink, and Green,¹ while the method for the assessment of adventitious motor overflow movements was based upon the procedure devised by Prechtl and Stemmer.¹⁸ The latter required that the children stand still with feet together, head upright, eyes closed, and arms outstretched with the fingers of both hands extended and separated for a period of one minute. During this time the examiner noted choreiform movements occurring in any part of the body. Observation was principally focused upon the face, limbs, and hands.

The ability to engage in imitative voluntary movement was evaluated by requesting the child to copy the movements of the examiner's fingers as they were selectively opposed to the thumb of each hand.

Speech and language functions were evaluated by observing the quality of the child's spontaneous speech during the course of the examination as well as his replies to a series of standard questions which included the naming of the parts of a pencil and the materials of which it was made.

In the evaluation of behavioral organization attention was directed towards the identification of manifestations of a particular sub-syndrome of behavioral disturbance frequently reported in association with brain injury in children. This syndrome, often referred to as a hyperkinetic behavior disorder, represents an amalgam of behaviors including hyperkinesis, distractibility, inattentiveness, impulsiveness, and meddlesomeness.^{2, 15, 16} During the examination particular note was made of signs of motor restlessness, the necessity to employ special techniques to secure the child's at-

tention, the degree to which instructions had to be repeated before the child would do what he was asked, as well as the need to prevent the child from engaging in extraneous activity. At the close of each examination a clinical judgment of hyperkinesis based upon both the number and the extent of disturbances observed was made. Subsumed under the general heading of hyperkinetic behavior disorder were children who exhibited all of the above mentioned patterns of disordered behavior as well as children who exhibited only one to a marked degree. Illustrative of the latter was a child who, although he was cooperative, attentive, and followed directions readily, was also observed to be constantly fiddling with whatever small objects about the examining room caught his eye. He turned the examiner's ophthalmoscope on and off repeatedly, used the stethoscope to auscultate both his own heart and the examining table, and managed to extract candy from a closed bag and eat it. He was perfectly pleasant when asked to stop any of these activities and did so readily enough, only immediately to initiate another.

Two types of abnormality were separately considered in the evaluation of the neurologic findings. The first type, to be referred to as "hard signs," represented findings that have been classically employed in neurologic diagnosis, and include abnormalities in reflex, cranial nerve, and motor organization, lateralized dysfunctions, and the presence of pathological reflexes.

The second variety of abnormal finding consisted of what were called "soft signs" of cerebral dysfunction,^{8, 22} and included language and speech disturbances that fell short of frank aphasia and dysarthria, clumsiness as reflected in inadequacies of balance, coordination,

and gait, the presence of adventitious motor overflow, difficulties in the execution of fine motor imitative movements, manifestations of extinction to double simultaneous tactile stimulation, and inadequate graphesthetic and stereognostic responses.

The findings on clinical neurologic examination made it possible to classify cases as: (1) Cases whose disturbances constituted an identifiable classical neurologic syndrome. (2) Cases in whom no identifiable classical syndrome were present, but in whom "soft signs" of central nervous system dysfunction were found. (3) Cases in whom no abnormal findings of either type were observed.

Clearly the presence of a neurologic syndrome such as spastic hemiplegia does not exclude the possibility that the child can also have "soft signs" of central nervous system dysfunction. However, in such cases, primary classification was based upon a consideration of the major handicap. Thus a disturbance of gait in a hemiplegic child was viewed as a reflection of his hemiplegia and not considered to constitute an additional soft sign.

RESULTS

Twenty-six (29%) of the group of

Table 1
NEUROLOGIC SYNDROMES ON CLINICAL
NEUROLOGIC EXAMINATION

NEUROLOGIC SYNDROMES	AGE IN YEARS			
	10	11	12	Total
Residual Quadriplegia	0	2	1	3
Residual Diplegia	1	1	0	2
Residual Hemiplegia R	3	3	2	8
L	0	2	5	7
Residual Monoplegia	1	1	1	3
Athetosis	1	1	1	3
Total	6	10	10	26

90 educationally designated "brain-damaged" children were found to have "hard signs" of central nervous system abnormality. The neurologic syndromes embraced by these cases are presented in TABLE 1. As may be seen in this table, residual hemiplegia was the most frequent finding with 15 cases classified in this way. The remaining cases were distributed among other subvariants of cerebral palsy, plegias, and athetosis. In all cases the motor impairment was mild, and with the exception of two of the children with monoplegias who were found to have significant limitation of motion of an extremity, the most striking findings were weakness and abnormal reflexes. Similarly, the motor impairment of the three athetoid children was mild and for the most part was confined to the presence of adventitious and tic-like movements primarily involving the head, shoulders, trunk, and upper extremities. These movements were most notable at rest and tended to diminish when purposive action was undertaken.

Findings in like-aged children who were in regular class placement were markedly different. None of these children had findings which would result in their being classified with respect to the syndromes present in almost one-third of the educationally designated subjects. Moreover no child in the group had any neurologic "hard sign" (TABLE 2).

When "soft signs" are considered, 81 (90%) of the educationally designated "brain-damaged" children are found to have one or more such findings. Included in this group are 22 of the 26 children who had previously been noted to have "hard signs" of central nervous system damage. Fifty-nine of the children, therefore, had "soft signs" in the absence of "hard signs." If the four children with "hard signs" alone are added to the 81 children with "soft signs" it may be noted that 85 (94%) of the educationally designated "brain-damaged" children have evidence of primary neurologic dysfunction.

When the "soft signs" of neuro-integrative disturbance are considered in greater detail (TABLE 3), it is found that of the 59 educationally designated "brain-damaged" children who have only "soft signs," 17.0% have one, 6.7% have two, 13.3% have three, 18.6% have four, 11.9% have five, 5.1% have six, 8.5% have seven, 8.5% have eight, 3.8% have nine, 5.1% have 10, and 1.7% have 11 such findings. The most frequently occurring "soft signs" involved disturbance of balance, coordination, and speech. The least frequent sign was an abnormality of position sense. Intermediate in their frequency of occurrence fell such findings as abnormalities in response to double simultaneous tactile stimulation, of mus-

Table 2
FREQUENCY OF DIFFERENT TYPES OF CENTRAL NERVOUS SYSTEM ABNORMALITY
IN EDUCATIONALLY DESIGNATED "BRAIN-DAMAGED" CHILDREN AND CONTROLS

	PATTERN OF NEUROLOGIC ABNORMALITY				Total
	Hard Signs Only	Hard and Soft Signs	Soft Signs Only	No Finding	
Subjects	4	22	59	5	90
Controls	0	0	5	10	15

Table 3

NUMBER OF SOFT SIGNS IN
"BRAIN-DAMAGED" CHILDREN WITHOUT
HARD SIGNS AND IN CONTROLS

Number of Soft Signs	Subjects n=64	Controls n=15
0	5	10
1	10	5
2	4	
3	8	
4	11	
5	7	
6	3	
7	5	
8	5	
9	2	
10	3	
11	1	

Table 4

DISTRIBUTION OF "SOFT SIGNS" IN 59
EDUCATIONALLY DESIGNATED
"BRAIN-DAMAGED" CHILDREN
WITHOUT HARD SIGNS

Soft Sign	n	%
Balance	39	66.1
Coordination	34	57.6
Speech	32	54.2
DSS	32	54.2
Tone	26	44.1
Choreatiform Mvt.	25	42.4
Gait	25	42.4
Imitative Mvt.	20	33.9
Graphesthias	19	32.2
Asteregnosis	14	23.7
Position Sense	2	3.4

cle tone, and of motor overflow movements (TABLE 4).

Findings in the normal controls were in marked contrast in the educationally designated "brain-damaged" children, with two-thirds of the controls showing no findings. Of the remaining one-third, in no instance was a child found to have more than one "soft sign" of neuro-integrative dysfunction (TABLE 3). In the main, abnormalities in the control group

were restricted to disturbances of muscle tone.

Of the 90 children educationally designated as "brain-damaged," 19 were found to have associated behavioral disturbances classifiable as the hyperkinetic behavior disorder syndrome. As may be seen from TABLE 5 the presence of "hard

Table 5

RELATION OF HYPERKINESIS TO
CLINICAL NEUROLOGIC FINDINGS

	Hyperkinesis		No Hyperkinesis	
	n	%	n	%
Children with Hard Signs	5	19.2	14	21.9
Children without Hard Signs	21	80.8	50	78.1
Total	26	100.0	64	100.0

signs" of central nervous system damage in these children was no more frequent than for the "brain-damaged" group as a whole. However the case for the frequency of "soft signs" of neurologic dysfunction was markedly different, with greater numbers of such signs found in the hyperkinetic children than in the educationally designated "brain-damaged" children who were without the syndrome. This finding is maintained when the children with and without "hard signs" of neurologic dysfunction are considered separately (TABLE 6).

The patterning of "soft signs" of neuro-integrative dysfunction was not related to the presence of behavioral disturbances. In TABLE 7, the rank order frequency of occurrence of the different "soft signs" in the children with and without hyperkinesis are presented. Children with the syndrome and those without the syndrome are markedly sim-

Table 6

RELATIONSHIP OF HYPERKINESIS TO THE NUMBER OF SOFT SIGNS
IN EDUCATIONALLY DESIGNATED "BRAIN-DAMAGED" CHILDREN
WITH AND WITHOUT HARD SIGNS OF CENTRAL NERVOUS SYSTEM DYSFUNCTION

	Hyperkinesis			No Hyperkinesis			t	p
	N	M	SD	N	M	SD		
Children with Hard Signs	5	3.40	1.51	21	1.09	0.70	3.33 ^a	<.01
Children without Hard Signs	14	5.79	3.05	50	3.84	2.77	2.29	<.05
Total	19	5.84	2.98	71	3.08	2.64	3.89	<.01

^a Because of a significant difference in the variances, the Cochran correction of the t test was used.

ilar in the relative frequency with which different "soft signs" of central nervous system dysfunction are present, with the correlations between signs in the hyperkinetic and nonhyperkinetic groups high and significant. Thus in this group of educationally designated "brain-damaged" children hyperkinesis is found to be associated with a general increase in the number of "soft signs" of central nervous system dysfunction but not with

an increase in any particular set of signs of neuro-integrative defect.

DISCUSSION

The findings of the present study can be considered in three ways: (1) By comparing the children educationally designated as "brain-damaged" with children of the same age who are educationally classified as normal. (2) By analyzing the neurologic findings within

Table 7

RELATION OF HYPERKINESIS TO FREQUENCY WITH WHICH
SOFT SIGNS OF CENTRAL NERVOUS SYSTEM DYSFUNCTION ARE MANIFEST

SIGNS	GROUP			
	With Hard Signs		Without Hard Signs	
	Hyperkinetic	Not Hyperkinetic	Hyperkinetic	Not Hyperkinetic
	Rank of Sign		Rank of Sign	
Speech	1	1	4	3
DSS	2	2	1.5	5
Imitative Mvt.	4.5	4.5	7	8
Choreatiform Mvt.	4.5	4.5	7	6
Tone	4.5	9	10	4
Graphesthesia	4.5	6	7	9
Coordination	7	3	3	2
Balance	9.5	9	1.5	1
Gait	9.5	9	5	7
Asteregnosis	9.5	9	9	9
Position Sense	9.5	9	11	11
	Rho=0.821, df=10, p<.01		Rho=0.725, df=10, p<.01	

the "brain-damaged" group itself. (3) By relating the neurologic findings in the "brain-damaged" group to findings on clinical neurologic examination in other groupings of aberrantly functioning children.

Comparison of the group designated as "brain-damaged" with the control children leaves little doubt that, at least in the educational system we have been studying, "brain-damaged" children do in fact have clear evidence of central nervous system dysfunction. Ninety-five percent of the children so designated were found to have some abnormality on clinical examination, with the overwhelming majority having either "hard signs" or two or more "soft signs" of neuro-integrative disturbance. In only 5% of the "brain-damaged" children were no abnormalities found. These findings stand in marked contrast to those of like-aged normal children none of whom were found to have "hard signs," and none of whom had more than one "soft sign."

The ubiquitous finding of signs of neurologic abnormality in the educationally designated "brain-damaged" children should not, however, obscure the fact of their neurologic heterogeneity. "Hard signs" were found in only one-third of the children, and even within this subgroup various disabilities were observed ranging from evidence of residual quadriplegia to signs of mild athetoses. Marked variability in findings was also characteristic of the remaining two-thirds of the group, with the number of "soft signs" in these children ranging from 0 to 11.

Up to now we have been considering the types of abnormality as they are found in the children. One may also examine the obverse of this problem and

look at the degree to which the particular signs were distributed. When this is done it is found that no sign was found to occur in more than two-thirds of these children. Abnormalities of balance, which were the most frequently reported, were observed in 66%; disturbances in coordination, speech, and extinction were found in slightly more than 50%. Less than one-third of the children were found to have evidence of graphesthesia, asteregnosis, or a disorder of position sense.

The neurologic heterogeneity of educationally designated "brain-damaged" children is perhaps most strikingly illustrated through the examination of the relation of the clinical findings to hyperkinetic behavioral disturbance. "Hard signs" were found no more frequently among the hyperkinetic children than among those who did not exhibit such behavioral disturbance. Although the hyperkinetic children were found to have a significantly greater number of "soft signs," the types of signs were not different from those found in the children who were without hyperkinesis. Thus the clinical neurologic findings in the hyperkinetic children were qualitatively indistinguishable from those of the remainder of the group.

The findings of the present study make it difficult to sustain the view that the designation of "the brain-damaged child" is merely an "administrative wastebasket" for poor learners or children with behavior problems.³ Clearly, at least in the school system we have studied, the overwhelming majority of such children do indeed have clinical evidence of central nervous system abnormality. It is striking that the level of abnormal findings in the group we have studied is even greater than that which

has been reported in the course of studying other groups of aberrantly functioning children and adolescents such as those referred to child guidance clinics concerned with behavioral and/or scholastic problems,^{8, 22} in psychiatric hospitals,^{10-12, 14} or in special schools for the mentally subnormal.⁴ Nevertheless, despite differences in the proportion of children affected, clinical evidence of central nervous system dysfunction has been demonstrated in association with the disorders of children deriving from these many diverse sources.

These findings suggest that neurologic damage, because of its locus, extent, time of life at which it is sustained, and opportunities for development with which it is associated, may result in a multiplicity of disorders ranging from mental subnormality to psychosis. It may well be asked if similar patterns of neurologic abnormality are found in such discrepant groups, does the term itself have any clinical usefulness. It would be easy to answer the question simply in the negative. Clearly such a designation does not directly define symptomology, treatment, or prognosis, and it is therefore inappropriate to permit the application of the label "brain-damage" to result in the assumption of either neurologic, behavioral, or educational stereotypy. The act of labeling is of positive value, however, because it directs our attention to at least one defined etiologic source for dysfunction (i.e., primary atypicality in the organization of the central nervous system) and thus may prevent us from attributing undue weight to the etiologic role of social environment or parental care. These factors may contribute to the development of disturbance, but probably do so most readily in interaction with organismic patterns.^{5, 20} A focus on

primary atypicality in the child highlights these considerations and directs our attention to the importance of defining the ways in which a child with a disordered nervous system may perceive and respond to his environment, both to understand the mechanisms of symptom formation and be in a position to develop techniques of effective intervention.

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THE ROLE OF GENETICS IN THE ETIOLOGY OF THE SCHIZOPHRENIAS

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Both experiential and genetic factors have been implicated in the etiology of schizophrenia but their relative roles have been impossible to assess. Recent studies using the technique of adoption to separate the effects of "nature" and "nurture" have shown that genetic factors play an important role in the etiology of schizophrenia and may also play a role in the development of other psychiatric illnesses.

In the past few years a body of impressive data has emerged demonstrating the role of genetics in the etiology of the schizophrenic syndromes. It is the purpose of this paper to summarize the findings of this research and discuss the relevance of these, as yet not widely known, studies.

Before proceeding, it might be useful to underscore the importance of such research. The schizophrenias are not uncommon disorders. The usual figure given for lifetime incidence is about 1%. This figure is based on hospitalized cases⁶; if the number of people hospitalized is only one-half to one-third⁷ of those who have the disorder, the preva-

lence figure must be doubled or even tripled. But the problem may be even more extensive, since the boundaries of the syndrome are so unclear. It is possible that conditions which bear a phenomenological resemblance to schizophrenia, such as schizoid disorders and borderline states, may share etiological factors as well. These latter disorders are extremely common; some clinics report (e.g. Gaw et al.⁸) that as many as one-half of their applicants have been so diagnosed. Clearly, then, what might be in question is the etiology of the disorder of a substantial proportion of the psychiatrically disturbed population.

What are the theories concerning the

genesis of the schizophrenias? Primarily they are explications of an observation of considerable antiquity: that there is a familial clustering of psychiatric disease. A suitably early reference may be found in Thomas Willis who wrote in 1685 that: "It is a common observation, that men born of parents that are sometimes wont to be mad, will be obnoxious to the same disease. . . ." In the intervening 280 years, studies exploring the etiology of the schizophrenias have implicated both genetic and environmental factors but have not yet been able to assess the relative roles of each factor in the development of the syndrome. These studies have employed two major lines of investigation:

1. Consanguinity studies—assessment of the prevalence of mental disease in the relatives of schizophrenic patients. Such studies^{18, 25} have demonstrated that there is a significantly higher prevalence of psychopathology among the relatives of schizophrenics as compared to the general population and that the closer the biological relationship the greater the prevalence of psychopathology in these relatives, culminating in the high concordance rate of schizophrenia in monozygotic twins. Results of such studies have been traditionally explained as due to the operation of genetic factors.

2. Psychodynamic and family studies—studies of the psychological environment to which schizophrenic patients

have been exposed. These studies^{1, 3, 17, 18} have revealed that schizophrenics have been reared in and exposed to a disturbed psychological environment. They have been interpreted to show that the disease is a learned reaction to, modeling after or identification with such familial pathology.

What makes interpretation of both types of studies difficult, if not impossible, is the confounding of biological and psychological relatedness: the deviant psychological experiences have usually been received at the hands of the patient's biological relatives. One cannot decide to what extent the disturbance of the schizophrenic offspring has been genetically or psychologically transmitted since the cognitive, affective, and child-rearing abnormalities of the parents might be the manifestation of a genetic disorder in the parents rather than the cause of the illness in the child. The data accumulated to date are compatible with both the biological and the social transmission of schizophrenia and do not permit the evaluation of the relative contributions of either.*

In the past few years a method of resolving this dilemma occurred independently to several people: Leonard Heston,¹¹ Jon Karlsson,¹⁴ and each of our collaborative team at the NIH—Seymour Kety,¹⁸ David Rosenthal,²³ and myself.²⁰ This method involves the study of persons adopted in infancy. Since in such circumstances the biological par-

* The studies of monozygotic ("identical") twins do provide some definitive information regarding the role of genetics in the etiology of schizophrenia. This information is usually incorrectly interpreted. Since in no study conducted today has it been found that 100% of "identical" twin pairs are concordant with regard to schizophrenia, one can only conclude that the etiology of the disease cannot be 100% genetic. However this does not document—as some people would seem to believe—that psychological factors necessarily play an etiological role in the development of the disorder. All that is nongenetic is not necessarily psychological: biological but nongenetic factors have been implicated in several such studies.²⁷ It is of some interest that the concordance rate of schizophrenia in monozygotic twins is approximately that of diabetes, a disease not generally regarded as primarily psychological in origin.¹⁰

ents are not the parents who rear the children, the transmitters of biological heredity and social experience are separated and their relative roles may be evaluated. Why this method had not been previously applied to the problem of the psychoses and why it suddenly occurred to several people at once is an interesting question; the technique had been used to evaluate the contributions of nature and nurture in intelligence 30 years ago²⁴ and to the problem of alcoholism²² 20 years ago.

THE ADOPTION STUDIES

Studies utilizing the technique of adoption have employed three approaches attempting to answer three questions. The first question is: Does heredity play any role in the etiology of the schizophrenia and, if so, what is the manifestation of the genetic diathesis? The two relevant studies are that of Leonard Heston²¹ and that of Rosenthal, Wender, Kety, Welner, Schulsinger, and Østergaard.²³ Both studies have evaluated the personalities of adults born to schizophrenic parents but raised from infancy in foster homes (Heston) or adoptive homes (Rosenthal et al.) Both studies have employed the obvious control group of children born to normal biological parents and reared in foster or adoptive homes. Heston's evaluations of subjects were made primarily on the basis of clinical interviews while the Rosenthal study employed psychological tests as well. At this time results of the Heston study have been fully analyzed, those of the Rosenthal study have not. Without describing the methodology of these studies—for which the reader is referred to the original articles—I would like to summarize the major results. In these studies the phrase "index group"

refers to the offspring of schizophrenic parents reared in foster or adoptive homes while the phrase "control group" refers to the offspring of nonschizophrenic parents reared in foster or adoptive homes. TABLE 1 presents the findings of each study and summarizes the results of both studies taken together.

In summary we find that about 9% of the offspring of schizophrenic parents become schizophrenic when reared in adoptive or foster homes as opposed to none of the offspring of nonschizophrenic mothers reared in adoptive or foster homes. The rate of 9% is well within the range of the percentage of offspring of schizophrenics who become schizophrenic when reared by their own parents. Likewise, more than 30% of the index group manifested psychiatric pathology in the schizophrenic or borderline spectrum as opposed to 6% in the control group. (These differences are highly significant statistically, $p < .001$, exact probability test.) In other words, about one-third of the offspring of one schizophrenic parent develop psychiatric disorders of a schizophrenic character even when they are reared away from their schizophrenic biological parents. This is comparable to the fraction who develop such pathology when reared by their schizophrenic parents.² The results of these two studies are apparent: there is a markedly increased prevalence of schizophrenic psychopathology among the biological offspring of schizophrenic parents, a finding strongly implicating genetic factors in the development of *some* forms of schizophrenia. Note that I state "some forms"—logically such a research design can (and has) only shown that some schizophrenic parents genetically transmit this disorder to their offspring. The design cannot

Table 1

DISTRIBUTION OF SCHIZOPHRENIC DIAGNOSES AMONG OFFSPRING OF SCHIZOPHRENIC PARENTS (INDEX CASES) AND NONSCHIZOPHRENIC PARENTS (CONTROL CASES)

	Schizophrenic	Borderline Schizophrenic	or Schizoid States	Other	Total
HESTON (1966)					
Index Cases	5	8		34	47
Control Cases	0	0		50	50
Schizophrenic+Borderline schizophrenics+Schizoid vs. "Others," $p < .001$ (exact probability test).					
ROSENTHAL ET AL. (1967)					
Index Cases	3	6	4	26	39
Control Cases	0	1	5	41	47
Schizophrenic+Borderline schizophrenics+Schizoid vs. "Others," $p < .02$ (exact probability test).					
COMBINED DATA					
Index Cases	8 (9%) ^a	18 (21%) ^b		60 (70%) ^c	86
Control Cases	0	6		91	97

The probability that the excess of:

^a Schizophrenics in the index group is chance, $p < .003$ (exact probability test).

^b Borderline schizophrenics or schizoids in the index group is chance, $p < .001$ (exact probability test).

^c Schizophrenics+borderline schizophrenics or schizoids in the index group is chance, $p < .001$ (exact probability test).

demonstrate the converse: that all schizophrenics have schizophrenic parents, or that all schizophrenics have a genetic component to their illness.

Two additional results—not cited in the tables—are of considerable interest. Both relate to what seem to be other manifestations of the genetic tendency. Heston's study revealed that in addition to the 5 schizophrenic subjects in the index group, 21 other index subjects manifested appreciable psychopathology, including 9 sociopaths* and 13 other personality disorders (emotionally unstable personalities and mixed psy-

choneurotic reactions). Among the control group there were, by comparison, 2 sociopaths and 7 personality disorders. The difference in frequency between the two groups is again significant ($p < .02$ for sociopathy, $p < .05$ for the personality disorders, exact probability test). The second unexpected result was that among those index subjects who demonstrated no psychiatric pathology Heston felt there were a large number of talented, creative, and colorful people—a provocative suggestion of the often cited relationship of madness and genius.

Let me reemphasize the first of these

* Eight were noted as "schizoid psychopath" and have been included in the category of "borderline schizophrenic" or "schizoid" states in TABLE 1.

two findings, which if replicated in other studies suggests not only that genetic factors play a role in the etiology of schizophrenia but that such factors play a role in the development of a wide variety of psychiatric difficulties. As will be seen, the evidence from the second group of studies supports this finding.

Although there is a preponderance of psychopathology among the offspring of psychotic parents, there is some psychopathology among the offspring of the control parents. What is the implication of this fact? Does it demonstrate that such psychopathology can originate without a genetic basis? Not necessarily. In both studies it is not asserted that the parents of the control subjects were psychologically healthy but only that they had never received psychiatric attention. What fraction of persons with the schizophrenic syndrome do receive psychiatric attention at some time during their lives? In the Rosenthal study it was found that of 20 persons who were schizoid, borderline, or schizophrenic, only one had ever received psychiatric care. Judging from the Rosenthal data—as well as population surveys, e.g., Mental Health in the Metropolis²⁸—only a small fraction of seriously disturbed persons do receive psychiatric attention. Accordingly, there is a fair probability that the control population's parents contained ill but undiagnosed persons. (This assertion documents the obvious—in general it would seem that women giving up their children for adoption are more apt to be disturbed than those who do not). Preliminary analyses of the Rosenthal data suggests that severity of psychopathology in the parent is not closely correlated

with the severity of pathology in the offspring; that is, borderline schizophrenic patients are as apt to have children in the schizophrenic spectrum as are chronically schizophrenic parents. If this is so, the psychiatric disturbance in the offspring of the control group may be due to genetic transmission from mildly disturbed and undiagnosed parents within this group.* Hence, there is no necessary reason for attributing disturbance to the offspring of the control group to psychological environmental factors. It is *possible* that the disturbances in both the experimental and control groups are entirely genetic. It is also logically possible that psychological factors do play a role in the development of psychiatric illness within both groups. One cannot make a decision between these two possibilities on the basis of these data. An obvious question relates to whether the experiences associated with adoption are psychologically noxious. One might then argue that some psychological experiences related to adoption interact with a biological predisposition to produce psychopathology in the index group. An admission that this is so is tantamount—because the control group did not in general become ill—to stating that the biological predisposition is so great that factors that do not make a genetically normal child ill will make a predisposed child severely disturbed; that is, genetically transmitted characteristics are *at least* necessary, if not sufficient. It is worth noting in passing that virtually no disease is entirely genetic. Even phenylketonuria, which is generally considered to be a “genetic disorder,” has an environmental component. The child who

* A method which might permit clarification of the above problem would be to interview and screen the parents of the control group, including only the offspring of those parents who manifested no psychiatric disturbance.

has the disease will become ill only if he eats substances containing the amino acid, phenylalanine. If most edible substances did not contain phenylalanine, a child with phenylketonuria would become ill only if he ate special foods, those containing phenylalanine. Since, in fact, most proteins do contain phenylalanine an afflicted child becomes ill under any natural environmental circumstances. (When such a child is fed a diet deficient in phenylalanine the manifestation of the disease may, perhaps, be avoided). Similarly, the genetically predisposed child might not become schizophrenic if reared in an unusual way. All that may be said from this data is that given an apparently adequate psychological environment such a child does become ill.

The first experimental design answers one question: Can schizophrenia be genetically transmitted? The answer is affirmative. This design cannot answer the question: What fraction of schizophrenics are genetically produced? To answer this question another design must be employed. In this second design one starts with adult schizophrenics, adopted in infancy, and determines which of them have psychiatric illness in their biological relatives. If schizophrenia is a genetically transmitted disorder, one should find an increased prevalence of schizophrenia among the biological relatives of the schizophrenics as compared to the biological relatives of normal adopted adults. Likewise, if schizophrenia is a psychologically transmitted disorder, one should expect to find an increased prevalence of psychopathology among the adopting relatives of the schizophrenic subjects.

Such a study has been conducted and is reported by Kety, Rosenthal, Wender and Schulsinger.¹⁵ These authors report

the prevalence of psychopathology among the biological and adoptive relatives of 33 adopted schizophrenics (the index cases) and 33 matched adopted nonhospitalized subjects (the control cases). The prevalence of schizophrenia and other psychiatric disorders among these relatives was determined by finding the number of such relatives who had received such psychiatric diagnoses from hospitals and clinics. The results are presented in TABLE 2.

As may be seen, there is a significantly increased prevalence of schizophrenia among the biological relatives of the adopted schizophrenics but not among the adoptive parents of these subjects. This result is highly significant statistically ($p < .05$, exact probability test). This result, too, is compatible with the genetic but not the psychological transmission hypothesis. Since Heston's study had shown that schizophrenic parents produced offspring with a variety of psychopathology, it was logical to reverse the process, that is, to ask how many of

Table 2
DISTRIBUTION IN THE RELATIVES OF
SCHIZOPHRENIC CASES AND
THEIR CONTROLS

	Relatives with Schizophrenia or Probable Schizophrenia	
	Biological Relatives	Adoptive Relatives
Index Cases (n=33)	11 (150) ^a	1 (74)
Control Cases (n=33)	3 (156)	3 (83)

$p < .05$ (exact probability test, one-tailed).

^a Figures in brackets indicate the total number of relatives at risk, e.g., for the upper left-hand cell, there were 150 biological relatives of adopted schizophrenics (index cases) and of these relatives 11 were schizophrenics or probable schizophrenics.

Table 3

DISTRIBUTION IN THE RELATIVES OF SCHIZOPHRENIC INDEX CASES AND THEIR CONTROLS

	Relatives with Schizophrenia, Probable Schizophrenia, Psychopathy, Character Disorder, Inadequate Personality	
	Biological Relatives	Adoptive Relatives
Index Cases (n=33)	20 (150)	4 (74)
Control Cases (n=33)	7 (156)	3 (83)

$p < .01$ (exact probability test, one-tailed).

the biological relatives of schizophrenic subjects had received comparable diagnoses. Accordingly, the following diagnoses were grouped together under the neologism "schizophrenic spectrum disorder": schizophrenia; probable schizophrenia; psychopathy; neurotic character disorder; inadequate personality. The results are presented in TABLE 3.

As may be seen, the prevalence of all these illnesses is significantly greater among the biological relatives of the schizophrenics ($p < .01$ exact probability test), a result again compatible with Heston's finding of a general increase of psychopathology among the offspring of schizophrenic parents.

The above study has one methodological and one logical weakness. The methodological weakness is that the diagnoses were made on the basis of formally recognized mental illness. Consequently the rates of illness among the relatives are too low. Likewise the "control group" may have been far from psychologically healthy because a weak criterion of health was used: that of never having received psychiatric therapy for mental illness. A logical weakness is that such a

method could only set a lower limit on the fraction of schizophrenics who have a genetic predisposition. The reason for this is as follows: For any genetic trait which is not transmitted by a simple dominant gene, not all of the family of a child with that trait will demonstrate it. For example, if both parents are carrying a heterozygous recessive trait, neither will show the trait and perhaps one or more of the children will show it. This is the usual state of affairs among the parents of children with phenylketonuria. In this study, at least one child, an adopted schizophrenic, showed the trait in question. If the trait were a simple recessive one, one would expect that about 40% of the sibships would not manifest that trait.* That is, even if the disease were *entirely* genetic, 40% of the cases would have a negative family history.

In neither of the groups of studies discussed was the psychological environment of the adopted schizophrenic evaluated. Proponents of the psychological mode of transmission^{1, 8, 17, 18, 20, 81} have clearly described the aberrant interpersonal and cognitive environment to which the future schizophrenic is exposed during his formative years. Al-

* In the Kety et al. study, the average number of sibs per patient was three—that is the average number of offspring per biological parent was about four. In this study, the actual number of sibships who did not manifest a psychiatric illness was about 65%. For further explication of this point see any textbook of human genetics, e.g., Curt Stern's *Principles of Human Genetics*.²⁸

Table 4
GLOBAL SEVERITY OF PSYCHOPATHOLOGY
RATING SCALE

- 1 Normal—without any disorder traits.
- 2 Normal—with minor psychoneurotic traits.
- 3 Psychoneurosis or mild character neuroses.
- 4 Moderate to marked character neuroses.
- 5 Severe character neuroses, moderate to marked cyclothymic character, schizoid character, paranoid character.
- 6 Borderline schizophrenia, acute psychoses.
- 7 Schizophrenic psychosis.

though such work is important, one cannot determine, as I have already explained, whether such an environment is a manifestation of illness in the parents rather than the cause of illness in the child.

To attempt to unravel this problem a third type of study has been conducted. In this study²⁹ the *adoptive* parents of schizophrenics were compared with a group of parents who had reared their own schizophrenic children. The par-

ents of these two groups and those of a third comparison group, the adoptive parents of normal adults, were evaluated with psychiatric interviews and psychological tests. At present only the psychiatric interviews have been evaluated. On the basis of these interviews each parent was evaluated and assigned a score on a global psychopathology scale which is shown in TABLE 4. The average severity of psychopathology among the three groups was calculated, and results are presented in TABLE 5.

The biological parents were considerably more disturbed than the adoptive parents of schizophrenic patients. The difference is highly significant ($p < .005$, *t*-test). Likewise the adoptive parents of the schizophrenic adults were somewhat more disturbed than the adoptive parents of the normal subjects—this difference is significant but less so ($p < .05$, *t*-test). Some sampling problems and a methodological problem (the interviewers knew

Table 5
FREQUENCY AND SEVERITY OF PSYCHOPATHOLOGY IN THE THREE GROUPS OF PARENTS

GROUP		1-2	2.5-3	3.5-4	4.5-5	5.5-6	6.5-7	Mean
Biological Schizophrenic	Fathers	1	1	1	6	1	0	4.2
	Mothers	0	0	4	3	1	2	4.9
Adopted Schizophrenic	Fathers	1	4	3	2	0	0	3.3
	Mothers	1	3	4	1	1	0	3.5
Adopted Normals	Fathers	2	6	2	0	0	0	2.6
	Mothers	2	4	4	0	0	0	3.0

Significances, one-tailed *t*-test:

Adoptive Schizophrenic Parents vs. Biological Schizophrenic Parents, $p < .005$.

Adoptive Schizophrenic Parents vs. Adoptive Normal Parents, $p < .05$.

Adoptive Schizophrenic Mothers vs. Biological Schizophrenic Mothers, $p < .05$.

Adoptive Schizophrenic Mothers vs. Adopted Normal Mothers, NS.

Adoptive Schizophrenic Fathers vs. Biological Schizophrenic Fathers, $p < .05$.

Adoptive Schizophrenic Fathers vs. Adoptive Normal Fathers, NS.

into which group the parents fell) dictate less than unqualified acceptance of these data; a replication is planned. Nonetheless, this experiment again suggests that the reported and here observed psychopathology in the parents of schizophrenic persons is a manifestation of a genetically transmitted disturbance in the parents rather than the cause of illness in the patient. This last assertion contravenes the mandate of one's psychological intuition. It is virtually impossible to see how the aberrant psychological environments that have been described can fail to leave their pathological toll. Perhaps the psychopathology among the offspring of schizophrenic parents reared in adoptive homes would be still greater if these homes provided the type of environments which have been deemed schizophrenogenic. Nonetheless, if these data are correct—and, as stated, the experiment needs replication—one cannot but conclude that the role of deviant psychological experiences in the etiology of schizophrenia has been overestimated.

DISCUSSION

I would like to turn now to some of the questions that have been raised but not answered by these studies.

1. *Schizophrenia Spectrum Disorders.* One of the most surprising findings of the Heston and Kety studies was the increased amount of nonschizophrenic pathology (i.e., psychopathy, character disorders, etc.) among the relatives of schizophrenic patients. Because of the designs of these studies such pathology

could not have been the effect of psychological causes but rather must have been due to genetic inheritance. To repeat, not only do some schizophrenias have a genetic basis but apparently so do some phenomenologically nonschizophrenic psychiatric syndromes as well.

If a graduated continuum of psychiatric pathology, a spectrum, does exist, the nineteenth century concept* of a neuropathological trait with varying manifestations may have to be exhumed and resuscitated. The efforts of nosologists to break the continuum of psychological malfunction into discrete nonoverlapping psychiatric diagnostic categories may be not only difficult (which is obvious) but impossible. Because of the difficulty nosologists have had in describing discrete nonoverlapping psychiatric diagnostic categories, some psychiatrists (e.g., Menninger²⁰) have argued that the reason for this continuum is that there really are no psychiatric diseases and that all apparently qualitatively different forms of mental illness differ only quantitatively; different forms of malfunction are the result of the degree of regression along a continuous path of psychological development common to all people.

The demonstration of a continuum often leads to an incorrect conclusion: because a continuum exists, no diseases exist. Without quibbling about the meaning of the word "disease" it should be obvious that although intelligence is distributed along a continuum, certain biological pathological states ("diseases") exist which produce low intelligence.

* The observation that mental disease—not particular forms of mental illness—cluster in families had been made considerably earlier. In his *Anatomy of Melancholy* published in 1651 Burton⁶ observed: "and that which is to be more wondered at, it [melancholy] skips in some families and goes to the son, or takes every other, and sometimes every third in a lineal descent, and does not always produce the same, but some like, and some symbolizing disease [my italics]."

Likewise, height is distributed along a continuum, but no one would argue that achondroplastic dwarfs or persons with pituitary giantism did not have "diseases." In summary, the existence of a phenomenological continuum of psychopathology in no way militates against the view that biological "diseases" exist in this continuum. The data discussed suggest that there may be an underlying continuum of biological disposition which is manifested in the observed symptomatic continuum.

2. *What Is Transmitted?* Another question, related to the one already discussed, is the question of what is transmitted. To begin with, what are the primary psychological traits that are inherited? Are they any or all of the "fundamental" psychological characteristics posited by several authors to form the psychological anlage of schizophrenia? A partial list of such traits would include: dissociation⁴; introversion¹²; weakness of repression; overreaction to anxiety-producing stimuli¹⁸; and anhedonia.²¹

A second question is simply the mechanism of genetic transmission. What gene or genes are involved? What are the effects of their interaction? What is their degree of penetrance?

A third related question regards what is biologically transmitted. Using the computer as an analogy to the brain, at least three possible mechanisms suggest themselves. (1) Some of the components (neurons) may be aberrant. In this model some groups of cells have a metabolic abnormality which might be manifested in a variety of ways including a raised or lowered threshold of excitability, lack of modification through use ("effective learning"), etc. Such aberrant functioning might be detectable with present biochemical techniques. (2) The wiring

may be aberrant. In this model the individual elements (neurons, vacuum tubes, transistors) function adequately but are interconnected incorrectly. Such an abnormality would probably be difficult, if not impossible, to ascertain with current biological techniques. (3) The inbuilt "programs" are aberrant. In this instance both the elements and their interconnections are adequate but the instinctive "programs" are aberrant. In a normal child certain complex patterns of behavior emerge on a fairly predictable timetable: stranger anxiety during the second half of the first year; separation anxiety during the second year; oppositional behavior during the second and third years. Such preprogramed behavior seems to fulfill an important role in normal development. As Levy¹⁶ suggests, without the period of preprogramed rebellion a two-year-old might not begin to develop independence; one might easily see a child lacking this program as becoming an excessively dependent and "good" child closely bound to his mother—in fact a child with some characteristics often described in preschizophrenics. An aberration in which the mechanisms were intact but the neural instructions which govern were somehow malfunctioning would be an abnormality whose biological basis would probably be impossible to detect with current techniques of biological analysis.

3. *The Role of Experiential Factors.* To begin with, what have these experiments demonstrated with regard to the etiology of schizophrenia? They demonstrate that biological factors—almost certainly genetic—play a predominant role in the etiology of some fraction of the schizophrenic syndromes. The followup studies—studies of the offspring of schizophrenics reared in adoptive homes—can logically demonstrate only

that schizophrenia can be genetic. Such studies cannot determine in what fraction of schizophrenias genetic factors are predominant. Studies of the relatives of adopted schizophrenics—the second class of studies discussed—should be able to help answer this question. As already discussed, even if the syndrome were entirely genetic, unless it were transmitted as a simple dominant trait (and it appears not to be), one would not expect to find a family history in all instances. (Certainly one would not expect all schizophrenics to be genetically produced. If some schizophrenic adults are, so to speak, “ex-schizophrenic children,” then since a large fraction of schizophrenic children suffer from organic brain damage,⁹ one would expect that the predominant etiology of some adult schizophrenic syndrome would also be organic brain damage).

A most important question not answered by these studies is to what extent (and how) experiential factors play a role in the genesis of the schizophrenias. The adoptive parents study could only show that some schizophrenics have fairly normal parents. But what are the effects of disturbed parenting? Can experiential factors alone produce schizophrenia? Some light may be shed on this question by a study, now in progress, of the psychological fate of offspring of normal biological parents reared by schizophrenic, presumably schizophrenogenic, adopting parents. Finally, how and to what extent do experiential factors interact with the documented biological factors? Neither the Heston nor the Rosenthal study employ a comparison group of adults reared by their own schizophrenic parents. Such a comparison group is necessary to determine if—and if, how much—deviant environmental factors contribute to the impaired

psychological and social functioning seen in schizophrenic individuals. It is possible that although schizophrenics’ offspring reared in adoptive homes are as apt to develop schizophrenic symptoms as when reared by their own parents (which the data seem to indicate), the severity and type of these symptoms may be affected by circumstances of rearing.

Theories regarding the genesis of psychopathology are many. Facts are less abundant. Most theorists acknowledge the importance of both constitutional (or hereditary) and experiential factors. Such assertions are not very useful. What is essential is specifying *which* kinds of experience interacting with *which* kinds of biological background *when* result in *what* kinds of personality development. The strategy of adoption studies may permit the construction of specific and useful theories, both for deviant and normal human psychological development.

SUMMARY

Previous research into the etiology of schizophrenia had been unable to assess the relative roles of experiential and genetic factors in the production of this syndrome. Recent studies, using the technique of adoption to separate biological and experiential factors, have permitted a partial answer to this question. Genetic factors have been demonstrated to play an important role in the etiology of schizophrenia and, in addition, evidence has emerged suggesting that genetically transmitted characteristics play a role in the development of other psychiatric illnesses. These data do not permit a full answer to the question of the extent of influence of environmental factors on the severity and nature of schizophrenic manifestations, nor do they demonstrate that, in all instances,

schizophrenia is determined by genetic factors.

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CONCEPT MODIFICATION IN INSTITUTIONALIZED DELINQUENTS

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Idiopathic meanings of various concepts (such as "me" or "sin") have a facilitating or inhibitory effect upon proper conduct. The study reported here demonstrated that meanings of concepts of important persons and behaviors to juvenile delinquents can be brought significantly closer to the meanings held by their nondelinquent peers by specially structured institutional treatment.

The net worth of any institutional approach to social conditioning or rehabilitation is always difficult to assess, particularly with respect to juvenile offenders. For practical reasons, evaluations have generally focused on various indices of overt behavior. Questions regarding more basic personality or intrapsychic modifications have ordinarily been skirted because of serious reservations as to whether institutional experiences could actually produce such modifications and, if they did, whether

these changes were measurable. The exigencies of contemporary social problems, however, have forced social scientists to lay aside these practical, often academic, reservations and face directly the need to devise treatment programs which could influence internalized meanings and values in more significant ways than have been apparent in the past. Essentially, one is faced with a learning problem in which the primary ongoing factors involved in the development of an individual's subjective reality^{3, 5, 9} must

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The research was carried out under the auspices of the Federal Bureau of Prisons at the National Training School for Boys, Washington, D. C., in consultation with the National Institute of Mental Health.

be dealt with within the limitations of the human, environmental, and substantive resources of a public institution. With a view to this problem, the present investigation evaluated those aspects of learning represented in the idiopathic meanings to delinquent boys of various personal and behavioral concepts (such as "me" or "sin") which are known to have a facilitory or inhibitory effect upon acceptable conduct,^{2,8,10,11} and then sought to demonstrate the possibility of altering such meanings through specially structured institutional treatment.

SETTING AND POPULATION

The setting for the study was a training school for youths convicted of federal crimes. Inmates live in cottages, each normally housing about 75 boys. The project involved two of these cottages (out of six)—one for an experimental group of 45 boys, the other for a control group of 40 boys. The two groups, which represented a cross section of the institution's population, were formed by dividing the odd-numbered from the even-numbered boys in the initial sample (attrition accounts for the small discrepancy in the final N for each group). A second, noninstitutional control group of 93 boys was drawn from a local high

school in a depressed area. Roughly three-quarters of both institutional and noninstitutional boys were from substandard income families (income figures were difficult to obtain and extremely unreliable, in part due to fluctuating contributions by various family members, discrepancies in claimed welfare receipts, and unreported income) while the remainder were, for the most part, from the middle-lower to upper-lower class. A minimal fifth grade literacy requirement was set (as measured by the Jastak Wide Range Achievement Test⁴) and, insofar as was possible, groups were selected to have closely comparable racial balance (in proportion to that of the overall institutional population), age, and IQ (see TABLE 1). As the project was conceived as a supplement to, and not a substitute for, normal institutional procedures, boys in the Experimental and Control Cottages participated in all regular institutional programs.

THE EXPERIMENTAL PROGRAM

The experimental variable, known as the Cottage Life Intervention Program (CLIP), had three divisions: the Activity Program, the Group Program, and the Individual Interviews. Each of these primary divisions was under the direct supervision of a single professional per-

Table 1
AGE, IQ, AND RACIAL BALANCE OF
EXPERIMENTAL, INSTITUTIONAL CONTROL, AND NONINSTITUTIONAL CONTROL GROUPS

	Experimental Group (n=45)		Institutional Control Group (n=40)		Noninstitutional Control Group (n=93)	
	M	SD	M	SD	M	SD
Age	16.33	0.74	16.39	0.67	16.98	0.88
IQ	93.24	6.26	93.12	5.69	98.45	8.76
Number of White	29 (64%)		26 (65%)		57 (61%)	
Number of Colored	16 (36%)		14 (36%)		36 (39%)	

son who acted both as consultant and coordinator for the particular program. In its daily aspects, the project was conducted by three counselors, each being assigned one-third of the boys in the Experimental Cottage whom he supervised in all phases of the program. The utilization of existing nonprofessional personnel in key organizing and therapeutic roles was an important feature of CLIP, and all the counselors were recruited from the regular custodial staff. Each of these men completed a group counselor training program directed by a consulting psychologist.

The Activity Program augmented established recreation schedules, such as weekly visits to the gymnasium, hobby/craft activities, and movies, making much greater use of existing facilities. In addition, one large area within the Experimental Cottage was equipped for pool, table tennis, crafts, and "table games." Game competitions were scheduled regularly. A second area was provided with materials for drawing, painting, sculpture, mosaics, etc., and an exhibition space was created. The Activity Program, which was conducted twice weekly, provided the sort of informal encounter between a counselor and his boys that is imperative if barriers between authority figure and boy are to be lowered; and, in time, these periods offered unique possibilities to observe a boy's typical interaction with his peers.

The Group Program involved both small group meetings (i.e., each one-third section of the cottage) and the Cottage Forum. The former, directed by the counselor, met weekly and concentrated on problems related to the overall institutional program. The latter was a weekly gathering of all members of the Experimental Group. It provided an occasion to complain, question, and gen-

erally explore any issue relevant to cottage life, on the order of a "town meeting." These sessions were conducted by members of the psychological services staff.

The Individual Interviews were designed to establish a more intimate relationship between each boy and his counselor, and provided three avenues of personal contact: (1) regular individual monthly interviews; (2) "call out" sessions, initiated by a counselor who felt a boy needed special attention, or by a boy who felt pressured by a particular problem; and (3) informal private discussions during activity periods. No limit was set on the number of "call out" or informal contacts.

Overall, CLIP sought to deal directly with such critical problems as insecurity, excessive hostility, anxiety, disturbed interpersonal relationships, low self-esteem, faulty identifications, and lack of motivation. By keeping each boy involved in continual and diversified activities, boredom and idleness were in great part reduced, tension was alleviated, and the probability of more constructive channeling of energy was increased.

THE EXPERIMENTAL CONCEPTS

Concepts were specifically selected to tap the areas of authority, self, responsibility, friends, threat, sex, and time. They were presented in the form of the following nouns or pronouns:

Mother	Fear	Sex
Father	Sickness	Girl
Teacher	Fighting	White
Policeman	Religion	Negro
Me	Sin	Time
Boy	Work	Friend
Trouble	Earn	Laughing

PROCEDURE

Administered collectively in a test booklet (one per page), each concept was evaluated on 18 dimensions; each dimension being defined by polar judgments on a seven-position scale, following Osgood's semantic differential technique.⁶ Words comprising the scales were chosen at the fifth grade reading level as determined by the word lists of Buckingham et al.¹ The scales represented three primary factorial groupings, identified as Evaluative (e.g., good—bad), Potency (e.g., thick—thin), and Activity (e.g., fast—slow). Meaning scores, based on scale values combined in factorial groupings or summed overall, provided the operational definition of a given concept. Difference scores (D-scores), which represented value differences on each scale between two groups on a given concept, allowed an instrumental comparison of meaning for each concept, as well as providing an index of change.

At the onset of the six-month experimental period it was established that, though meaning values of the experimental concepts were essentially the same for the Experimental and Institu-

tional Control groups, these values for both groups differed significantly from those of the Noninstitutional Control Group (TABLE 2).

It has been demonstrated⁷ that different positions on a seven-position, bipolar scale involve different degrees of anxiety tolerance and, consequently, represent varying levels of judgmental difficulty. In evaluating the data, semantic differential scale positions were divided into three categories: the extreme positions (1 and 7); those intermediary (2,3,5,6); and the central position (4). These categories are considered, respectively, lowest to highest in the degree to which anxiety is involved in the judgmental process. Position 4 choices represent a type of "noncommitment" and can be thought of as a withdrawal from the affective challenge of a given scale dimension.

These correlates of test-taking behavior formed the basis of a secondary hypothesis, which held that by reducing tension and increasing the self-confidence necessary to venture direct and refined judgments, CLIP would significantly reduce the discrepancies between the relative frequencies of endorsement

Table 2

COMPARISON OF COMBINED FACTORS OVER 21 CONCEPTS FOR
EXPERIMENTAL, INSTITUTIONAL CONTROL, AND NONINSTITUTIONAL CONTROL GROUPS
BEFORE EXPERIMENTAL PERIOD
(Comparisons made by Wilcoxon's Matched-Pairs, Signed-Ranks Test)

	N	T	Z	P
Experimental Group Pretest vs. Institutional Control Pretest	21	106.0	.330	ns
Experimental Group Pretest vs. Noninstitutional Control Group	21	0.0	4.014	.001
Institutional Control Group Pretest vs. Noninstitutional Control Group	21	1.0	3.980	.001

Table 3

COMPARISON OF PRETEST D-SCORES WITH POSTTEST D-SCORES FOR EVALUATIVE, ACTIVITY, AND POTENCY FACTORS FOR EXPERIMENTAL AND NONINSTITUTIONAL CONTROL GROUPS AND FOR INSTITUTIONAL CONTROL GROUPS AND NONINSTITUTIONAL GROUPS
(Analysis by Wilcoxon's Matched-Pairs, Signed-Rank Test)

	EVALUATIVE				ACTIVITY				POTENCY			
	N	T	Z	P	N	T	Z	P	N	T	Z	P
D _N -Scores of Experimental Group vs. D _N -Scores of Non-institutional Control Group	21	36.0	2.624	.004	21	64.0	1.790	.037	21	32.0	2.724	.003
D _N -Scores of Institutional Control Group vs. D _N -Scores of Noninstitutional Control Group	21	98.5	.591	ns	21	85.5	1.043	ns	21	76.5	1.355	ns

of the various scale positions of the Experimental Group and the Noninstitutional Control Group.

RESULTS

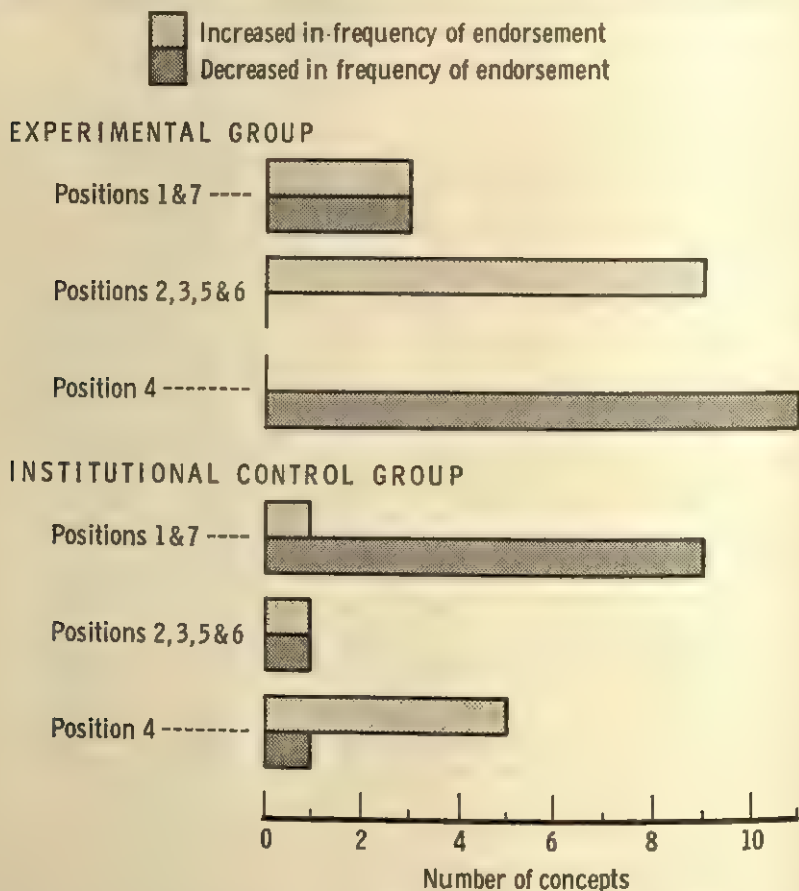
Pretest meaning scores of both institutional groups were found to differ significantly from the Noninstitutional Control Group, but not from each other, in each of the three factor groupings of scales (this is consistent with the pretest values of summed scales shown in TABLE 2). Data were evaluated so as to determine whether the pretest differences (D-scores) in concept meanings between the institutional groups and the Noninstitutional Control Group were significantly different from posttest D-scores. The expectation that the Experimental Group would significantly modify the idiopathic meanings it attached overall to the experimental concepts, in the direction of the meanings assigned to these concepts by the Noninstitutional Control Group, was fully supported by the results. TABLE 3 shows pre-to-post test comparisons by factors. As indicated, the relationship of pretest and posttest D-scores of the

Experimental and Noninstitutional Control Groups changed consistently beyond the .05 level of chance. No significant change was found between pretest and posttest D-scores of the Institutional Control and the Noninstitutional Control Groups.

The secondary expectation, that boys in the experimental program would develop higher anxiety tolerance and consequently show an improved ability to refine judgmental commitments (as reflected in changes in test-taking behavior) was also solidly supported. On the retest the Experimental Group showed significant increases for 3 concepts in the use of extreme scale positions, and significant increases for 9 concepts in the use of intermediary scale positions. Significant decreases were noted in the use of extreme scale positions on 3 concepts, and while there were significant decreases on 11 concepts in the use of position 4, not a single concept showed an increase in the frequency of endorsement of this center position. The Institutional Control Group, whose test-taking style was expected to be essentially unchanged,

Figure 1

COMPARISON OF EXPERIMENTAL AND INSTITUTIONAL CONTROL GROUPS
IN TERMS OF NUMBER OF CONCEPTS IN EACH GROUP SHOWING A CHANGE
IN FREQUENCY OF ENDORSEMENT OF .05 LEVEL OF CHANCE OR BETTER IN
ANY OF THE SCALE POSITION CATEGORIES



produced an unexpected pattern. Significant decreases were noted in the use of the extreme scale positions on 9 concepts, and on one concept in the intermediary positions. Significant increases were found in the use of the center scale position for 5 concepts, while there was a significant increase for only one con-

cept each in extreme or intermediary scale judgments (FIGURE 1). In terms of response "direction," then, the Experimental Group moved away from non-commitment toward strong, and particularly toward refined, judgments, while the Institutional Control Group showed a reverse trend, distinctly away from

strong commitments, with primary response increases in noncommittal position 4 judgments.

DISCUSSION

These findings suggest that significant modifications in the conceptual experience of the social deviant are possible, in a relatively short period of time, within the framework of a corrective institution. Since a delinquent's actions relate dynamically to the way he develops meanings for the world around him, such modifications imply a much sought-after increase in potential for positive changes in overt behavior. The study demonstrated that the raw materials needed to produce this meaningful influence on the subjective reality of an adolescent boy are, in great part, already available in public institutions, within the ranks of nonprofessional personnel, and within existing programs and facilities which can be more gainfully exploited.

The rather striking, unexpected increase in constrictiveness in the response style of the untreated Institutional Control Group clearly suggests a decrease in anxiety tolerance, greater insecurity and, by implication, generally worsened adjustment under the "normal" institutional regimen. Such an implication is

really an indictment of the institution's present system, and one is compelled to explore the possibility that even well-considered corrective schemes now in general use may, in important ways, be more debilitating than rehabilitating in net psychological effect.

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FATHER PARTICIPATION IN INFANCY

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Although the importance of paternal influence on child development is now generally accepted, we actually know very little about normal father-infant relationships. This study, undertaken to define some of them, found a wide variation among a homogeneous middle-class group. No factor was consistent for infants of both sexes. But results showed enough significant correlations to support the need for more developmental studies.

An increasingly large body of research literature documents the significance of paternal influences on child development.⁹ By far the largest number of studies on paternal factors have contrasted children, particularly males, reared under father-present and father-absent conditions. Significant differences have been reported in such areas as sex-role identification,^{5, 6, 13} cognitive style,^{1, 8} intellectual level,⁴ and factors related to behavioral disturbance.^{7, 10} Father-presence seems, therefore, to imply some functional relevance to child development, although we actually know very little about father relationships with children—particularly in the earlier years. The situation is perhaps analagous to an earlier point in psychological re-

search when important consequences were found to be associated with "maternal deprivation." This concept assumes psychological meaning only insofar as we understand something of the nature of normal mother-infant interaction. This study represents an attempt at describing some aspects of father-infant relationships and their range of variation in a middle-class sample.

Developmental theory has generally little to say regarding the impact of the father on early child development. Several factors, however, suggest the possibility of influence. Research on parental roles² has pointed out that, for the American middle class, families have become increasingly child-centered and greater homogeneity has occurred in

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parental roles. The balance of power within the family has shifted, with fathers yielding parental authority to mothers while taking on some of the nurturant and affectional functions traditionally associated with the maternal role. It is possible that this shift may result in greater psychological closeness between father and child.

Although fathers generally spend relatively limited periods of time with young infants compared to mothers, a father may take on relatively great stimulus value because of his novelty or salience to an infant. Thus, brief but more dramatic or striking interactions may have consequences of some significance as a result of their very contrast with the familiar daily routine associated with the mother. This can, of course, work two ways. The infant may also have a level of intrinsic interest and appeal to the father which is heightened because he does not experience many hours of sustained contact.

A further consideration is the greater potential range of variation that is possible in paternal behavior. In many middle-class homes, everything that the father does is essentially optional, i.e., he really does not *have* to change diapers, bathe the baby, provide for sleep and stimulation, and soothe or modulate periods of stress and high arousal. A mother normally must attend in one way or another to all these needs; in doing so she exhibits the stylistic variation that is considered so important in the child's development. Fathers, on the other hand, can vary to a great degree in both the extent and style of involvement with the infant because there are relatively few obligatory interactions. These factors suggest the possibility that there may be measurable effects of paternal behavior in

early infancy. Relations between dimensions of paternal behavior and a number of infant differences were therefore also explored in this study.

SUBJECTS AND METHOD

The sample consists of 45 families and their first-born infants (21 male and 24 female). The fathers were between 19 and 40 years of age and their education ranged from the completion of 11th grade to the possession of a professional degree. Their mean age was 27 years, mean education three years of college. All lived in the greater metropolitan area of Washington, D. C. Subjects were actually recruited into a larger longitudinal study⁸ during the mother's last trimester of pregnancy from local obstetricians, hospitals, and parent-education groups.

The data reported in this study were secured primarily from home visits that were made when the infant was 8 months old and again at 9½ months. Interview data were secured on father participation at the second visit. The focus of these observations and interviews, however, was on infant developmental differences, particularly "stranger anxiety" and "separation anxiety." For these purposes, there were also structured situational tests at certain points in the visit. For example, shortly after entering and explaining the procedures to the mother, one of the researchers went over to the baby, picked him up, and held him. The infant's reaction was then noted by the second researcher who served as an observer and a recorder.

It causes me great embarrassment to report that the actual data on father participation were secured by interviewing the mothers. Perhaps we did not have the courage of our own convictions to do a proper observational study or

reorient our work schedules to coincide with the availability of fathers. We viewed this as an exploratory effort; if any positive findings were generated, this would justify further effort and more detailed investigations. In defense of the data, there are a number of safeguards to minimize distortion or error. In the first place, virtually all questions were directed at a clearly behavioral level rather than being more inferential or evaluative, e.g., after an open-ended inquiry into the caretaking area, we asked specifically how often the father may feed the baby, change diapers, or give a bath. The fact that middle-class culture has some ambiguity regarding paternal roles (whether fathers should be highly involved with babies or primarily oriented to their instrumental roles) makes many of these questions less subject to distortion by clearly defined cultural expectations. There were also very few items requiring retrospective recall where one would expect a greater possibility of error or distortion. Finally, this was the first child for all families; both the baby and the nature of developing or emerging parental roles were very prominent in their minds.

Independent ratings of the interviews were made from the observer's notes for purposes of reliability, but the actual scores used in data analyses were jointly arrived at after differences were discussed. All together, eight measures of paternal behavior were obtained. I would like to describe these measures and convey some idea of the range observed. These may be seen as descriptive differences in middle-class homes which will subsequently be related to infant differences.

The first three variables reflect some aspects of positive, nurturant involve-

ment if we were to plot them on a circumplex model.¹¹

The first variable, *Caretaking*, was rated on a 9-point scale on the basis of the variety and frequency of caretaking activities. Inter-rater agreement was .98. Five cases (10% of our sample) were at the highest point on the scale, meaning quite literally that these fathers do not engage in caretaking activities. They may have given a bottle or changed a wet diaper under duress in the past month or two, but there is no report of other activity such as bathing, feeding solids, dressing, etc. Six cases were at the highest point on the scale, meaning that they engaged in two or more caretaking tasks on a daily basis, as well as possibly "optional" chores such as washing diapers or getting up at night. There was no significant difference on this scale related to the sex of the infant, although scores for males were numerically higher.

The second variable, *Investment*, is somewhat more global although the behavioral referents are fairly specific. It overlaps with caretaking and other activities performed with the baby, but it includes especially positive affective or emotional involvement from an early age. This rating was also on a 9-point scale and inter-rater agreement was .83. There was no significant sex difference.

The third measure, *Time Spent in Play*, was the result of a very detailed inquiry of how the father spent time with the baby during mornings, evenings, and weekends. Play was defined without regard to stimulation level and therefore includes "roughhouse," active play as well as gentle, subdued, or cautious play. A problem with the measure is that at lower levels of stimulation, play blends into merely being with the baby. The score is the sum over the various periods in a week described by the mother, and

therefore does not involve rater agreement. Our sample had a mean of slightly under eight hours spent in play in a week with virtually identical scores for boys and girls. This score may be inflated by the "being with" time, although the lowest score was only 45 minutes. Two scores were in the 19-20 hour range and one mother reported 26 hours.

The next set of three ratings define more negative components of interaction. Discriminations were more difficult to make, resulting in the use of 5-point scales.

The fourth variable, *Irritability Level*, defines the father's irritation threshold and reactivity to the baby's prolonged fussiness or crying. Inter-rater agreement is .85. The low point on the scale, obtained by nine fathers, implies patience, tolerance, and Job-like containment in the face of a fussy or irritable infant. The high point, obtained by 10 fathers, implies high reactivity and an open expression of anger or irritation with the baby's fussiness. Eight of these 10 had female infants, but the variability within each sex was enough to eliminate a significant sex difference.

Variable 5, *Apprehension Over Well-Being*, is an inference of the father's anxiety level. It is based on such behaviors as his expressions of concern whether the baby is warm enough when going outside, whether a doctor should be called when the baby is ill, or who picks up the baby first when he falls or gets hurt. Inter-observer agreement was .84. This measure is the only paternal variable on which there is a clearly significant sex difference ($p < .01$), being higher for females than males. Ten out of 13 scores of 5 were for girls. Perhaps this is a reflection of cultural sex-typing that boys *should* be tough and hardy at an early age and therefore one need not be as concerned

with their well-being, or possibly fathers are just more unsure with female infants.

Variable 6, *Authoritarian Control* was somewhat harder to define at this point in infancy, and the inter-observer agreement was only .67. Eleven cases received scores of 1, which would reflect a very permissive or tolerant attitude in relation to the baby's "getting into things." Seven fathers had scores of 5, implying a high degree of restrictiveness and a readiness to slap or spank to enforce control efforts.

Variable 7, *Stimulation Level of Play*, represented a rating of play with the infant ranging from gentle and cautious to highly excitatory and arousing. Inter-observer agreement was .87. A sex difference was certainly expected, but the higher score found for males was not statistically significant. Almost one-third of the sample (14 cases) received scores of 5; possibly this is a variable where a cultural value favoring "roughhouse" play for fathers is operating. On the other hand, 10 cases had scores of 1, which meant they were very gentle and cautious. Some mothers related that they were criticized by their husbands for being too rough with the baby.

Variable 8, *Overall Availability*, has no psychological content; it was an estimate of the average number of hours in a week the father is in the home when the baby is awake. We were interested in the extent to which a father's particular work schedule, commuting requirements, and recreational or other outside interests might limit or set restraints on his involvement with an infant. Our group had a mean of 26 hours per week in the home when the baby was expected to be awake, with a range from 5 to 47 hours. This was greater than we expected and indicates considerable time for potential interactions.

RESULTS

One of the six infant measures, attachment to father, is specific to the father-infant relationship, while the others relate to infant differences observable in situations or settings not involving the father.

Attachment to father was defined specifically in terms of the age of onset and the intensity of *greeting behavior*. By this we mean directed smiles, vocalizations, increased motor activity, and a general level of excitement upon seeing the father after some period of absence, usually when he enters the home in the evening. Depending on the infant's motor skills, creeping or crawling over to the father may also occur. This notion of attachment means primarily that the father has acquired some degree of positive reinforcement value to the infant and perhaps there is an expectancy of pleasurable interactions. Inter-observer agreement was .83 with a 5-point scale. A score of 3 or above means there was some greeting behavior of recent onset or earlier. Approximately three-fourths of the sample show this level or more intense attachment. There is no sex difference on the measure. Of the one-fourth of the sample who did not show attachment, in two instances there were aversive reactions to the father around the eighth month; that is, there were indications of distress or protest when the father approached and held the infant. One other baby showed this response to the father, but had also displayed some earlier greeting behavior.

TABLE 1 shows the correlations between paternal behavior and attachment to the father separately for males and females. There are four significant correlations for males and one for females.

Table 1

RELATIONS BETWEEN PATERNAL BEHAVIOR AND INFANT'S ATTACHMENT TO FATHER

PATERNAL VARIABLES	MALES FEMALES	
	(n=21)	(n=24)
1. Caretaking (.98)	.67 ^b	.05
2. Investment (.83)	.79 ^b	.35
3. Time Spent in Play	.10	.38
4. Irritability Level (.85)	-.53 ^a	.06
5. Apprehension Over Well-Being (.84)	-.14	-.45 ^a
6. Authoritarian Control (.67)	-.03	-.11
7. Stimulation Level of Play (.87)	.61 ^b	.05
8. Overall Availability	.28	.09

Inter-rater agreement in parentheses, where applicable.

^a $p < .05$.

^b $p < .01$.

No measure was significant for both sexes.

Caretaking, investment, and stimulation level of play are positively correlated to attachment for boys. Irritability level is negatively correlated for boys and apprehension over well-being is negatively correlated for girls. All tests of significance are two-tailed.

Infant differences that go beyond the immediate relationship with the father were examined next. These include three observational measures: (1) the infant's reaction to a strange male's approach, (2) indications of distress in a situation involving separation from the mother, and (3) the baby's spontaneous social approach behavior. Two other measures were obtained by maternal report: (4) indications of differential responding (either approach or distress) to male or female adults outside the family, and (5) sleep disturbances. Forty correlations (the eight paternal variables times these five infant variables) were computed separately for each sex. By chance,

we would expect two correlations to be significant at the 5% level within each group. That is just about what we found, so these results will be reported in summary fashion only.

Authoritarian control was correlated with separation protest ($r=.63$, $p<.01$). This may be of some special interest because males were significantly higher than females and our separation situation involved leaving the baby in the same room with two strange male adults while the mother went to another part of the house or apartment. Whether the sex of the strangers present is relevant we do not know, but Tennes and Lampl¹² report a parallel positive relationship ($r=.78$) between *maternal* "inhibition of aggression" and separation anxiety in a situation with female observers present.

The second significant finding for males is a positive correlation between stimulation level of play and the baby's differential responding to male and female adults ($r=.53$, $p<.05$). This variable implies that the infant seems to prefer one sex or another in spontaneous approach situations or shows less distress to one sex or another in situations where stranger anxiety appears. This also is a variable where males were significantly higher than females.

Among girls, the only significant correlation found was between authoritarian control and frequency of sleep disturbances ($r=.42$, $p<.05$). These were defined as spontaneous awakenings during the night, accompanied by crying or fussing for no apparent reason (i.e., not related to hunger, loud sounds, etc.). This also appears to be a plausible relationship, although there is no way to check against chance associations except by replication.

DISCUSSION

Granted the limitations of the data from the outset, what can we conclude from these observations? In overview, we have a distinct impression that the majority of these fathers were highly involved with their first-born child. This would be consistent with the views offered by Bronfenbrenner² that fathers are assuming many more nurturant and child-centered behaviors. We are also struck by the high degree of variability in this relatively homogeneous sample. Along with a possible reflection of personality differences, perhaps the range of differences is related to this being a period of some cultural change with varying degrees of change rates among different segments within middle-class groups.

The data on attachment warrant some special attention. For boys, the occurrence of greeting behavior appears highly related to readily defined paternal behavior; both positive and negative associations are of a relatively high order. With girls, however, the factors affecting attachment are much less clearcut. Indeed, it almost appears that there may be different attachment systems operating. This is especially suggested because five of the eight variables are statistically significant but none is consistent for both sexes.

One other implication of the different pattern of relationships for boys and girls has to do with the direction of influence. Two of the variables significant for boys—stimulation level of play and caretaking—have a distinct *action* emphasis. Neither variable shows a significant sex difference at this age but both are related to attachment for boys. At older age periods it might be expected that fathers will become more active with

boys and more gentle with girls. The data suggest the possibility that sex differences in patterns of responsiveness could be at least partially related to these expected changes in paternal behavior. Another way of stating this is that fathers are reinforced in their action emphasis with boys but not with girls.

The final point we wish to make has to do with our theoretical models for sex-role development in males. The larger proportion of the male sample, for whom we saw relatively clear attachment, had fathers who were nurturant, actively but patiently involved with the baby, and more emotionally invested in his up-bringing and development. These fathers were behaving according to what social learning theory postulates are the conditions which facilitate identification with the father. The one quarter of the sample who did not show attachment to the father (which included two cases where there was an aversive reaction to the father), whose fathers were more distant, less actively involved, and possibly more anxiety arousing, would be predicted to have minimal identification with the father according to social learning theory. On the other hand, this situation in infancy is compatible with a model of defensive or anaclitic identification for sex-role development. The point we wish to make is that there may be different avenues of identification depending upon the father-son constellation which emerges in early infancy. Rather than argue which theory is better, perhaps it would be more fruitful to attempt to define the special conditions of applicability for both models. Obviously to do this, many more developmental studies, with first-hand observational data, are

needed. Our results, tentative as they are, support the proposition that father-infant relationships are of greater significance than previous research attention would suggest.

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CLINICAL

CONJOINT MARRIAGE THERAPY WITH A HUSBAND-AND-WIFE TEAM

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Husband-and-wife therapists treating couples conjointly add a dimension of reality not available with unmarried co-therapists. This paper discusses the advantages of heterosexual therapy with couples. It then describes the differentness of transference and identification when the therapists are also a couple, the problems of tension between the therapists, selection of therapist couples, and the personality patterns of patients treated.

A four-and-a-half year pilot study of a new concept in the treatment of married couples with problems in sexual adjustment and interpersonal relationships with their children has been completed at the University of Minnesota outpatient clinic. This new approach was made possible by advances in interactional psychotherapy^{8, 10} and in the understanding of sexual physiology⁵ and psychology.^{2, 4} It involved husband-wife co-therapists, of whom the husband was a psychotherapist but the wife had no previous training in therapy.

In working with a married couple, the co-therapists kept the emphasis on the couple's interaction and the marriage, and at the same time tried to help each spouse see the contributing distortions in his own background. Four-way therapy seemed especially suitable for accomplishing these goals because it reduces individual transference problems and the possibility of either patient feeling that he is participating purely to assist in the treatment of his mate. Our clinical impression to date is that the approach is promising enough to

warrant the description furnished in this paper.

The goals of this pilot project were two: (1) to test the effectiveness of short-term conjoint therapy for sexual difficulties in marriage and their reflection on the family, and (2) to test the feasibility and applicability of a husband and wife working as a therapeutic team, with the idea of teaching the method to psychotherapists and their wives.

A direct analysis type of therapy was used, in which we supplied the couple with formulations about the causes of their conflicts and the meaning of their interaction rather than waiting for these to be developed by the patients themselves as in long-term therapy. The concepts of interaction and communication employed in the analysis were those described by Satir¹⁰ and Haley⁸ and those found in the traditional Freudian view of Oedipal problems. Psychoanalytic guidance was provided by one of the authors (ONR) as a check for the therapists on the formulations in the direct analysis method.

Treatment was limited to 16 weeks. Such a deadline put pressure on the patients to deal actively with their problems and expressed our expectation that they would and could make some change in the time allotted. We felt that if a couple were to make any useful change, it should be evident by the end of four months. Couples could return for more therapy later.

We decided on heterosexual co-therapy after talking with Masters⁶ about his study of human sexual function. He found that males functioned sexually better when a woman was included on the investigating team. If this were true in working with sex physiology, there might be a similar advantage

for males in psychotherapy for sexual problems to have a female therapist on the team. For centuries the problems of sex have been described and treated with a male bias. A few women have had something to say about sex in the past 50 years, but with limited effect. When a female therapist is actively involved on a team, however, the therapeutic interaction reflects feminine attitudes, affording a more complete and correct interpretation of the meaning of marital and family interactions than might occur with male therapists only.

The list of co-therapists is growing—two males, two females, unmarried heterosexual teams, and a few married pairs who are working with couples and families individually or in groups. In commenting about these teams Mintz⁷ states, "Many psychoanalytically orientated therapists expressing themselves not only in verbal exchange but also in the literature maintain that co-therapy with two male therapists or two female therapists offers precisely the same advantage to the patient as a group led by therapists of opposite sexes. Therapists who take this position state, with considerable clinical justification, that regardless of the therapist's sex the patient will consciously or unconsciously react to one of the two male therapists as a woman or choose one of the two female therapists to take the male transference role. They maintain further that therefore the sex of the therapist does not really matter—a point of view, which to this writer seems equivalent to discarding reality all together." Mintz feels that this is reality distortion of gender which reenforces the neurotic's wish to be one of the opposite sex and reenforces the sexual uncertainty of the psychotic patient. Heterosexual co-therapists who

are not married to each other simulate a marital pair. In fact, Sonne and Lincoln¹² call their co-therapist relationship a "therapeutic marriage." Actual marriage of the therapists adds another dimension of reality.

ADVANTAGES OF HETEROSEXUAL CO-THERAPY

A co-therapist of the opposite sex can react in a way that will correct bias or provide further elaboration which would not be in the experience of a single therapist. Two therapists have a greater chance of observing things that a single therapist might miss, so that more complete therapy can go on in a shorter period of time. If one therapist pushes a patient too hard, the other therapist can soften the pressures; or, if a patient is being too harsh with his mate, the therapist of the same sex can support the abused partner.

When both therapists are present in the total interaction, less collaborative time is necessary outside of the sessions and the goals of therapy are better agreed upon. If a husband starts individual therapy and arrangements are made for collaborative therapy of his wife, his wife and her therapist may work together to solve problems for the husband rather than working for change in her or in the relationship. Co-therapists work with a mutuality of interest and investment in both patients when all four are in the same sessions.

Co-therapy reduces the problem a single therapist has in avoiding the role of a judge or referee when he works with couples. Each spouse is in the habit of presenting the problems of the family as he sees them, anticipating that the listener will decide who is right and who is wrong and hoping that on the basis

of this decision the problem will be settled. Therapists are often used in this way even though they studiously avoid being judgmental.

Co-therapists monitor each other as to content and method. If one of the therapists intellectualizes at length with one of the patients, for example, the other therapist can bring this to awareness and change the pattern of interaction.

ADVANTAGES OF TREATING THE COUPLE AS A UNIT

It is possible in individual therapy to assist the patient to grow in his life such that he will either leave his mate or create confusion in the relationship until his mate makes a complimentary change. In conjoint therapy both partners are helped to understand their intrapsychic and interpersonal conflicts and also gain in understanding each other. They learn about the defects in their system of interaction and both are exposed to more useful ways of interacting. Moreover, both spouses are present in the therapy sessions so each one knows what occurs. Neither can guess wrongly nor be misinformed by the other as to what has gone on. This reduces the possibility of one in the pair using therapy as a club against the other one, and if that does occur it can be dealt with rapidly.

When one of the pair is treated alone, the untreated one may fear that the problem is a deep and mysterious difficulty in his mate. He may however resent his mate's transference shown by pleasure in therapy and positive regard for the therapist. He may resent that his partner is getting something that he is not, and be troubled by changes in the treated mate especially if the mate becomes hostile. The wife in one couple

we treated had had several years of individual therapy for frigidity before we started working with them. Her husband's attitude was a sceptical "here we go again." He was relieved to find that he was to be included in therapy, that there was no mystery, and that there was something in it for him. In another couple, the husband came along at first because we insisted that this was the only way we would treat his wife for frigidity. He was surprised to find that he contributed to the problems of his wife and children and that he had to look at himself rather than merely coming in to help her function better.

Contrasted to conjoint therapy, individual therapy can be used actually to perpetuate a dysfunctional marital relationship. One man, as an example, asked for psychotherapy for impotence experienced with his wife so that she would think he was working on his problem. He refused to include his wife in the therapy. He was satisfied with the surface appearance of a normal family that included children by adoption. Although the couple's relationship was hostile, he was not interested in changing that relationship because he was potent and sexually satisfied with a mistress.

There is an advantage in observing the interactional system of every couple *in situ*. In individual therapy the story the therapist gets of interaction is incomplete or one-sided. Listening to and observing it often shows both husband and wife to be using the same dysfunctional behaviors in the family. They are equally adept at shaming, blaming, and attacking each other and their children. Many act on the basis of a double bind such as "I demand that you love me spontaneously." "If you love me, you

will show it in my way. If you don't, you don't love me and I have a right to be angry." Since these behaviors are not labeled as such by patients, they are not apt to be reported in individual therapy. The patient is less aware than the therapist of its importance or even unaware that such behavior occurs. In conjoint sessions the couple not only learns to recognize what is dysfunctional but can learn more functional interaction and thus help each other in practicing new ways of relating between sessions.

Conflicts that occur in mating are fed by resentments. Using the sexual area as an example, whatever intrapsychic blocks to sex the ostensible patient has, they are triggered by his mate's behavior. This does not mean that the mate is to be blamed but reflects the transactional feedback nature of the problem. When both are treated in the same sessions they learn that the difficulty is not the fault of one or the other and can see how each one contributes to their not getting along together.

As one partner works on a problem and becomes aware of how it developed and how it can be resolved, the other gains some understanding of his contribution to it. Or, as is often the case, one is relieved to find out that his partner's difficulties stem from early learning and that he is thus not totally to blame for his partner's problems and can be less defensive and more helpful.

Understanding the Oedipal bind relieves guilt and anger. One woman felt that she was to blame for her husband's hostility toward her and was angry about his lack of consideration. She was relieved to find out that his feelings about women were learned long before in interaction with his mother and that her own

contribution was less than she had imagined. Her anger with him softened when an appropriate part of it was directed toward her mother-in-law, while her husband dealt with his hostility more appropriately by resolving feelings about his mother rather than giving his wife the brunt of them.

Oedipal conflicts are dealt with as a secret between patient and therapist in individual therapy. We see advantage and see no harm in considering Oedipal difficulties openly in conjoint therapy. Couples blame each other for too much parental attachment, too much parental control, or too much dependency on parents. They learn about the distorting aspects of each other's early conflicts and traumas and seem to have little trouble in talking about early seductions, abuse, or neglect when they are together. As this becomes open they tend to be more supportive of each other. Together they can often fill in more detail about past learning than either one would recall or see as significant if he were in therapy alone. In one couple we treated, the woman became quiet and withdrawn whenever any issue came up which she thought would anger her husband. She could not tell us how she learned to give up in any disagreement with a male. Her husband told us of an incident that occurred in their dating period when she bought some tight-fitting slacks to which her father objected. Her father demanded that she return them and her mother defended her and urged her to keep them. Her husband said that this support by her mother against her father was a rare event and that as a response to it her father went into his shop and carried on a loud and angry tantrum. The woman repressed this event which must have been descrip-

tive of many interactions in her family. She had learned to be quiet and give up to keep her father from falling apart. In therapy she learned that she was safe to assert herself, and her husband was able to permit and encourage her to speak out. She also learned to be more assertive with their children and to relate with them more actively than her husband felt she had done in the past.

This understanding of interaction in the original family also serves to get marital expectations or entitlements¹ out in the open. These expectations of what each one should do and expect of the other in marriage are learned in the original family and each one brings a different set of expectations into marriage which he defends implicitly as universal truth. Partners are often left to outguess each other about these expectations, and if one spouse does not guess correctly and behave in agreement with expectations of the other then the other one feels wronged, unloved, and resentful. An exchange of understanding of the Oedipal origins of expectations makes them explicit so that they can be discussed and mutually agreed upon or dropped in favor of behavior which the couples work out for themselves as mutually acceptable in the present time.

TRANSFERENCE-COUNTERTRANSFERENCE

Four-way heterosexual therapy provides some different aspects of transference. The relationship between the patient couple and the therapists couple is emphasized.

Some therapy teams first see patients individually for several sessions and then join forces later. This is reported as a workable method, but it may take the emphasis off the relationship of the pa-

tient couple and may cause each to be overly dependent upon his therapist to solve his problems. It also can contribute to a fight about: "My therapist is better than your therapist." In starting all together we offer assurance that openness is safe, that the problems of the marital relationship are to be considered as well as individual growth. When the patients become acquainted with the therapy method and develop comfort and interest in the process, usually after the first three sessions, then we obtain separate sexual histories and elicit problems which they are not yet ready to discuss in conjoint sessions. Only occasionally will a patient ask for a separate interview later in therapy, and at that time we encourage him to be open in the conjoint sessions and urge him to bring his concerns back into those sessions.

Mintz⁷ feels that patients who would choose a therapist of the less dreaded sex in individual therapy are enabled to work through their problems with the therapist of the more dreaded sex in the co-therapy situation. We previously mentioned that Masters⁶ sees males as more comfortable when a female is included as a co-investigator. And we have found that either one of a pair will express comfort because one or the other of us is present.

Couples view us in two ways—as parents and as a successful marital pair. Patients who cannot comfortably expose their sexual difficulties in their parental families can talk to us as parent surrogates. This holds for general problems of family interaction as well, since their sexual complaint is only a symptom of general dysfunction of interaction. We avoid judgmental or dictatorial behaviors such as they have experienced with parents and we do not support one mate

against the other. As parent substitutes we urge them to recognize and avoid old, automatic, maladaptive behavior and to work out mutually agreeable patterns that fit their present reality. We agree to talk about any problem they bring up. Even though our couples come with the primary complaint of sexual difficulty, they are resistant in talking about it so we pursue the problem with openness and persistence. Analytically speaking, this recreates and modifies the family transference situation. By acting within and focusing upon the relationships of the therapy pair and the patient pair, couples are afforded a more adequate working through of the Oedipal conflicts that underly much of their marital distress. We interfere rapidly with the tendency of the patients to form dyadic relationships with one or the other therapist. The efforts at dyadic relationship duplicates the initial family patterns wherein the patient could relate to only one parent at a time when seeking attention, judgmental direction, or dependency gratification. We turn the couples to working with each other to encourage their commitment and involvement with each other rather than with a therapist-parent substitute. The problem of dyadic behavior is then related to their children so they can see how they get at each other through their children and build dyadic relationships with the children on the basis of, "I am a better parent than you are." Most of these couples need help in developing a full commitment to each other by dropping commitment to parents and separating themselves from the control of parents. They are in effect delayed adolescents.

Mintz⁷ says that in heterosexual co-therapy the occasional transference deadlock can be resolved and that trans-

ference resistance can be resolved more rapidly than it may in other modes of therapy. We have seen very few transference hang-ups. It is possible that patients have less tendency to fantasize extratherapeutic involvements with either of us or to fantasize about our extratherapeutic interaction because they know we are married.

When we agree with each other about what is happening in therapy or when we resolve different reactions or permit each other to keep different opinions, patients see us as a successfully married couple. We relate pertinent events from our past interaction with each other or in our family, each giving his own interpretations of the conflict and its resolution. This gives the patients a model of how to resolve differences but does not impose any behavior pattern on them. Our toleration of differentness demonstrates that differentness need not impair marriage, that it is not to be equated with rivalry, and that it need not contribute to a struggle between mates. In therapy we demonstrate an easy exchange of leadership developed out of comfortable self-esteem, attention to self-awareness, and positive awareness of the other.

TENSION BETWEEN THERAPISTS

As in any relationship, tensions arise between co-therapists. Mintz⁷ views personal friction between the therapists as the greatest hazard in this type of treatment. In group situations this can lead to the patients forming coalitions with one or the other therapist, and she reports dissolution of a group in which this occurred. She feels that harmonious leadership hinges on basic good will and the ability to resolve differences in the therapy situation as well as outside.

Sonne and Lincoln¹² describe at length the problems they face in maintaining a co-therapy team "marriage." They comment on the time and effort this takes between therapy sessions to resolve the problems between them created by the patients' transference and their countertransference. And they report favorable therapeutic effect when the patients are aware of their quarrels and the ways they are resolved. They say, "Stress and distortion in the co-therapy relationship forces therapists to clarify their positions relative to one another, in reference to their views of current dynamics, perception of reality, socially shared psychopathology, open discussion of sexual material, importance of appreciation of feeling, male and female points of view, value systems, trust, etc. Perhaps the most important of all, they are forced to struggle with different notions of man-woman and what constitutes a man-woman relationship."

We feel that our marriage provides a distinct advantage in resolving the tensions that develop between us. Marriage at best is a complicated and difficult interactional process. To be successfully married requires mutual commitment and ways of effectively resolving differences. We find that resolving tensions arising about therapy is no different than, or separate from, our on-going process of tension resolving. Marriage offers more time and opportunity for resolutions of differences than is available to unmarried co-therapists. A marital pair can have the added supports of loving experiences and involvement with children. Operating from a base of complementary interaction, we can freely trade off leadership in therapy without either one being concerned about who is on top. We strive to maintain open-

ness in communication and awareness of self and awareness of the other. Our ability to capitalize on individuality and differentness is best expressed by a willingness to "agree to disagree" without loss of face. We have had no occasion to quarrel about events in therapy, perhaps because our quarrels about other things suffice. In addition to our own on-going efforts to resolve our problems in therapy, we have weekly conferences with our co-author in which we air differences and get help on avoiding pitfalls in therapy and on working together on the formulations of dynamics and therapy. We place considerable value on this objective evaluation and validation.

SELECTION OF THERAPISTS

Although we feel that husband-wife therapists have some advantages over others, marriage per se offers no guarantee for therapeutic effectiveness. To be able to work together a marital pair must have a functional marriage and family, with openness and no fight over control. They must be interested in working together and willing to take some risks. If the male has been working alone as a psychotherapist and his wife has not, he risks a change in his wife's fantasies about his therapeutic greatness when he comes under the eye of her reality appraisal—and he may risk criticism for including an untrained partner in the therapy process.

Rioch et al.⁸ report favorably on her experience in training mature women to be psychotherapists with the designation of "mental health counselor." She worked with a committee to choose candidates from a group "who were minimally defensive and pretentious. We looked for people who could see behind the words to deeper and sometimes con-

tradictory meanings, those who caught on quickly to psychological subtleties. We also thought it important to choose people who could work together in a group. Reliability and good general intelligence were, of course, required." The nine candidates chosen had a B.A. or B.S. or higher degree. They were 30 to 49 years of age, and six of the nine had experienced psychotherapy or psychoanalysis. Although the candidates were exposed to a variety of testing procedures in being selected, she concludes that the routine testing of all candidates is not indicated. She goes on to say, "Although our selection seems to have been a fortunate one, we have no way of knowing whether we actually chose the best of the applicants."

Schofield,¹¹ in speaking for the need for more people to answer the "pressing demand for psychotherapy," suggests that a new profession be created to train people as psychotherapists. He feels that such people should be selected from those with a sound general intelligence who have shown a reasonable social interest, ability to work effectively with others, and with a variety of experiences in group activities.

Rosen⁹ says, "There have been indications that particular individuals with little or no special training can be effective as psychotherapists. While these indications are encouraging, they are not always creditable. Yet I have abundant experience indicating that some individuals really are well suited for this work, although they may be lacking professional credentials or professional ambitions. For instance, many of the individuals who have worked with me as assistant therapists have been responsible—even devoted—and have been therapeutically effective in their work. . . .

What counts are the personal assets and liabilities of the particular individual." He goes on to say that he feels the most effective way to train psychotherapists is by having them in the therapy situation observing him. This is the way marital pairs with one therapist and one untrained can begin working together.

RESULTS AND COMMENTS

The couples we have treated came with the primary complaint of sexual incompatibility. They did not have organic diseases to account for their trouble. Some of them had never had orgasmic or coital experience; others had success in masturbation, in early marriage, or with other partners. In all the couples the sexual complaint was a symptom of a dysfunctional relationship in the marriage and in the family, and in none was it an isolated symptom or the single causal factor.

We used the admitting complaint as a screening device to see what kinds of couples would present themselves for therapy. These patients fell into two general groups: (1) Over 25% were labeled as passive-aggressive personalities. In over half of the marriages one or both partners showed this pattern. They were characterized by being chronically hostile, chronically aggressive, and impulsive, but at the same time being over-controlled and inhibited. They had excessive expectations of themselves and others which made them demanding and perfectionistic. They expressed anger and other feelings obliquely or indirectly and in ineffectual ways. They experienced sporadic outbursts of rage, especially under the influence of alcohol, followed by remorse and anxiety because the very security they tried to preserve by over-control was threatened. (2) The rest of

the sample was similar with respect to expectations and impulsiveness but without the conflicts provided by the over-controlling inhibitions. They appeared to be selfish, lacked consideration, and were unable to compromise. Both types suffered from a poor self-esteem and wanted their mates to make them feel better. Both had difficulty in developing or tolerating closeness.

There were two other types of difficulty. In one, both the patients were overly dependent. The woman wanted to depend on her husband, be petted and cared for, have her husband do the deciding. But the husband was also dependent and wanted to be cared for and have a wife who made the decisions. Thus both had unmet dependency needs. Conflict arose when they wanted to be dependent on each other at the same time, and many times they turned to their children for their own dependency gratification. In the second type of conflict, the men were more positive in character, more stubborn and resistant to change, while the women tended to be shy, introverted, and socially insecure. Most of these patients showed a pervasive low-grade depression which expressed their dissatisfaction over expectations not met, their anger and hostility, and their conflicts in dependency. Patients with these two types of character disturbances are generally considered resistant to change in individual therapy. In co-therapy treatment of the couple, change can occur and the learning of new ways of interaction is facilitated by treating couples' interactional and communication systems, dealing rapidly and openly with repetitions from the past, and providing suitable models of male-female interaction in the person of the therapists.

In evaluating the results of therapy, we considered it successful in those couples who reported a change in sexual function and family interaction to the degree that they were satisfied with the result. Of our first 44 couples, 27 (61%) completed the 16 therapy sessions. Of these, 21 were rated as successful and 6 were not successful. Seventeen couples did not complete the series; of these, 5 were successful and 12 were unsuccessful. Thus, 57% of our couples are rated successful. Seven of the couples proceeded to divorce.

In general, 16 sessions in conjoint co-therapy was sufficient to show whether couples could make movement or not. We do, however, feel that we should have continued longer with some of the couples, particularly those who had not consummated their marriages. Those who improved were asked to continue working by themselves. A few returned later for one or two refresher sessions.

In the past two years, we have extended the number of therapy sessions for selected couples and we find the method is useful in treating patients with other kinds of problems. An example is a couple in which the male was compulsive and the female passive-aggressive. He had failed in his educational program, was totally disgusted with marriage, and blamed his wife for all his anxieties, disappointments, and failures. Early in therapy his wife divorced him but they continued to work together. He developed insight and change with remarkable rapidity and she learned to be more forthright. They remarried and he is back in his educational program. The initial disturbance in this man was such that he would not admit that he had any

difficulties or needed to do anything about himself. He came into our program in order to get his wife straightened out. If he had gone into individual therapy at that time, his prognosis would have been nil. The speed and depth of his change have impressed all four of us.

We have now added a marathon group experience to our therapy program. This experience adds to a couple's growth and awareness and reinforces their communication in the broader social contacts. Our co-therapy works well in the marathon setting and with the same advantage that we have described for couple therapy. We have on one occasion included an older child with equal success.

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ULCERATIVE COLITIS AND THE COMMUNICATION PROCESS

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Psychosexual hypotheses about dynamics of psychosomatic conditions are reexamined in light of medical facts. It is proposed that these hypotheses have value in that they communicate about the experience of being ill with these conditions—in terms of effect on the patient's self-image and the environmental responses stimulated by his symptoms.

A study of ulcerative colitis reported by Fullerton, Kollar, and Caldwell,⁵ stated as one of its major conclusions: "We reject those hypotheses [of etiology] which have focused on particular aspects of the panpsycho-pathology [of ulcerative colitis patients] in an attempt to establish symbolic etiologies for the somatic symptomatology or to link the illness to specific difficulties in the mother-child relationship during a circumscribed phase of development."

The patient sample of their study

consisted of 45 men and 2 women, hospitalized in Los Angeles between 1955 and 1959 for current attacks—moderate to critical—of ulcerative colitis. All patients had been referred to the psychosomatic service for psychiatric evaluation, where they received psychiatric and psychologic examination. Criteria for admission to the sample were positive sigmoidoscopic and radiologic findings of active ulcerative colitis, as well as the absence of amoeba or pathogenic bacteria in repeated stool specimens.

The patients and their case histories

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were particularly studied for: (1) mode of onset, (2) history of premorbid bowel difficulties, (3) incidence of other psychosomatic or psychiatric diseases, (4) reported precipitating events, (5) the affective status of the patient at the time of onset, (6) descriptions of the parents, (7) reports of sexual adjustments, and (8) MMPI profiles. In most of these areas, the findings were incontrovertible.

The mode of onset of disease was recorded for 62 episodes, with 67% having bleeding precede or accompany onset of diarrhea, and with 33% having diarrhea precede gross blood in the stools. The authors commented that this finding detracted considerably from etiology hypotheses that considered diarrhea to be of primary significance, such as "motility hypotheses" and those that "assign a symbolic meaning to diarrhea."

Premorbid bowel difficulties were reported by 28 patients (60%), including 15 reports of nonbloody diarrhea with stress, two reports of vomiting with stress, two reports of chronic constipation, and two reports of alternate diarrhea and constipation. The authors considered this finding compatible with the Wolf "stock bound" hypothesis of propensity for ulcerative colitis patients to react to stress with their large bowels. However, other psychosomatic or psychiatric diseases were found in the case histories of 42 patients (88%), including 9% previous major psychiatric illnesses, nine patients with histories of X-ray-proven peptic ulcers, and two patients with then-present, concomitant peptic ulcers. These findings were taken to cast doubt on the "stock bound" stress hypothesis, as well as on those theories proposing symptom specificity: "This multiplicity of other previous psychosomatic and psychiatric ailments

... is not easily explained by concepts based on specific chronic nuclear emotional conflicts, constitutional factors, or specific experiential or conditioning influences prior to the onset of the disease."

Psychiatric and psychologic examination of patients and their case histories—including present status, sexual adjustment, MMPI—revealed "open and severe psychopathology among the ulcerative colitis patients. This is in contrast to patients with other psychosomatic illnesses, such as peptic ulcers where the degree of psychopathology is spread over a wide range from 'near normal' to severely disturbed." The panpsychopathology consistently found present was taken as "evidence of their defective ego structure that predisposes them to a morbid response to object loss." A preeminence of depression was found both clinically and through testing. Combined with low indices of activity, this finding suggested "a special quality of the depression of patients with ulcerative colitis." "They seem to be overwhelmed." "Observation suggested that the depression coincided with or preceded the somatic process, rather than resulted from it." "It appears . . . correct to look upon the affective and somatic manifestations of the illness as concomitant expressions of a more basic psychobiological process."

Information about the patients' parents ("controlling, hostile, overprotective mothers who usurp important ego functions of their children" and "weak, ineffective fathers who either impotently and indiscriminately raged against everything and everyone or who meekly avoided the family battleground by physical absence or alcoholism") and patient sexual adjustment ("prominent

themes of homosexual concern and heterosexual impotence") further emphasized the presence of defective egos, according to the authors.

Reported precipitating events indicated a high ratio of "object losses or the loss of a major narcissistic source of gratification. The affective response of depression to this stress . . . appears to precede or run concomitantly with the somatic response." The authors elaborated: "Although our study does not suggest a psychophysiological mechanism more specific than morbid grief, it does raise doubts about hypotheses which attempt to link the somatic process with psychopathology arising from difficulties in the mother-child relationship during the anal period of development. Although many of our patients had considerable psychopathology that could be called anal, this was no more impressive than psychopathology (purportedly) stemming from other developmental periods." "It seems more rational to view the panpsychopathology of these patients as secondary to their defective ego structures, and not to be lured into elaborate formulations which assign specific etiological value to symptomatic expressions."

The implications of these statements are obvious. Fullerton and his colleagues present evidence that refutes hypotheses about ulcerative colitis revolving about the concept that psychosomatic conditions find their specific origins in specific trauma at specific periods of psychosexual development. They endorse a rejection of the theorizing approach that takes direction from possible symbolic values of various symptoms of the condition. They emphasize the general, biologic significance of the symptoms, concentrating on psychophysiological stress processes while rejecting the symbolic.

There are several ways of reacting to the apparently irreconcilable conflict between these psychosexual-symbolism hypotheses and the clinical findings presented in the Fullerton et al. paper. One of the less complex reactions would be to reject one or the other of the two sides to the conflict and reaffirm the other. Another reaction could be to point out the similarities and differences of the two opposing points of view, consider the various philosophic implications of these, and at the same time call for more elaborate statistics, additional studies with more sophisticated methodology, examination of concepts in ancillary areas, etc. This approach neatly puts aside the confrontation, no one is scalded, and further developments are projected into some indeterminant future.

However, there is present a perhaps more complex, but certainly more fruitful, opportunity. The Fullerton et al. article, with its medical facts, cannot itself be rejected or watered down. Additionally, there are considerable other studies in the psychosomatic field that corroborate the general position of that article. Several of these are mentioned in the article; there are others^{2, 6, 12, 14} which would require excessive space to review here. But two others are appropriate for quotation at this point.

Kubie¹⁰ wrote: "What then of the concept of specific personality types and personality profiles [in psychosomatic conditions]? . . . I have found it increasingly difficult to reconcile these points of view with my clinical observations and my theoretical development. . . . There is much positive evidence against [specificity]. . . . I have been impressed by the dissimilarities at least as vividly as

by the similarities among the individuals in each clinical group."

And Knapp⁹ stated: "Eliminative processes may be related to important trends in emotional life in a more specific sense, as Alexander suggested. I would agree, however, with those who feel that his global vector model was too simplified."

Even so, it would be unwise to dismiss summarily the psychosexual hypotheses or to pervert their richness by scientific double-talk. These are the products of very creative minds. The chances are favorable—considering their source—that they have some core of wisdom, perhaps if examined in a different orientation from that in which they were originally presented.

With this goal of advancing the science through confrontation of these two apparently disparate viewpoints, two questions present themselves as helpful:

1. How to explain this disparity between the medical facts about ulcerative colitis and the picture of the illness communicated by the psychosexual hypotheses?

2. Often, two viewpoints which are arrived at from different bases are incompatible at first appearance, but are found to be reconcilable with each other on closer scrutiny. How could the picture presented by the medical facts about ulcerative colitis be reconciled with the apparently incompatible psychosexual hypotheses?

With regard to the first question, a reasonable explanation for the disparity immediately presents itself. That is, this disparity is not caused because the medical facts are wrong or because the proponents of the psycho-

sexual hypotheses had defective vision or deficient powers of interpretation. But rather, the latter were simply looking in the direction opposite from what they seemed to be looking and from what they thought themselves to be.

This idea must be expressed again differently, for clarity. The psychosexual hypotheses may not be medical discussions of the abnormal physiologic processes at work within the person suffering a psychosomatic condition. They are, however, excellent and accurate statements of how these conditions affect consciously *and* unconsciously the external environment. In other words, these hypotheses may not inform about the actual disease process, its genesis, its inception, even its cure. But they do reveal a great deal about the illness as a communication process and a communicative experience. They tell what messages can be generated in the mind of the observer (or "receiver," in communication terms) by the stimulus of the manifestations of the disease.

Freud⁸ discovered early that he was interpreting the dream symbols recounted by his patients in his own symbolic language (i.e., personal symbols which meant something to him but not to his patients), but later the patients learned to dream with his symbols, to communicate to him via his symbols. Similarly then, the psychiatrists who have presented these psychosexual hypotheses are presenting, through their insight derived from self-understanding, information about the symbolic meanings that can be ascribed by anyone to the various physical symptoms of a disease.

With regard to "looking in an opposite direction" these hypotheses tell little,

if anything, about a disease process as it exists in the body of a patient. The hypotheses do tell us much, accurately and richly, about the psychological and emotional reactions that a psychosomatic illness such as ulcerative colitis stimulates in the people who surround and deal with the patient. They inform us as to the symbolic meanings that are unconsciously and even consciously at times attached to disease symptoms.

Kubie¹⁰ wrote about this phenomenon, "We must also bear in mind that disability, disturbances in function, and mutilations have a chain of consequences which arise through their symbolic implications on three psychic levels: the realistic or conscious level; the preconscious; and the deeper symbolic or unconscious level. This brings three more groups of variables into the picture, making it impossible for any illness or trauma, however simple it may be intrinsically, ever to have only one universal implication." And, "These variations in the symbolic meanings of illness are among the subtlest and the most inconsistent of all the variable forces which are at work in determining the ultimate psychosomatic picture."

For example, with ulcerative colitis the psychosexual hypothesis that describes diarrhea in terms of "the infant's emotional evaluation of the excremental act—giving up a cherished possession" does not offer any information about the physiology and pathology of the disease process. It informs, however, about the unconscious, symbolic pictures that can be stimulated in the mind of the observer. These pictures can be assumed to be found in the minds of anyone in communication contact with the patient. They are pictures of a person regressed

and being deprived, pouring out his substance without consideration for his own needs.

Or, again, what about the idea of diarrhea representing an explosive, hostile fusillade? Here the message stimulates a picture of hostility and attack. The bystander is stimulated to reactions of being the object of an elemental form of aggression (shit on you!). In the article by Knapp⁹ quoted above, he wrote, "The communicative aspect of all these manifestations (of human behavior) is important. All are like psychosomatic symptoms, arising from a complex, powerful chain of physiologically mediated pressures, they become part of the communicative social universe."

The distinction between psychosomatic illnesses and conversion reactions is underscored by these considerations. The psychosomatic symptom is primarily unintentional communication. It fundamentally reflects stress physiology at work and messages conceived to be communicated by the psychosomatic symptom are derived in the mind of the beholder. They are results, rather than causes. On the other hand, conversion reactions are tied up in a primary fashion with communication. As expressed elsewhere,¹⁶ conversion symptoms "appear to be a way of communicating emotional stress symbolically, and symptoms may contain clues to the content of the unconscious conflict."

At this juncture comes a touchy question. Since these psychosexual hypotheses tell nothing about physiologic stress mechanisms, rather are descriptions of conceptual and reactive processes stimulated in observers, why bother with them? They are the associations of

the observer. This situation is somewhat similar to that in the joke about the two psychiatrists in the elevator, where one is goosed by the other. He is just ready to turn around to remonstrate when he suddenly thinks, "That's his problem, not mine." What do these psychosexual hypotheses have to do with ulcerative colitis?

In considering this question, some points raise themselves that make possible a broader perspective, and also allow at least partial reconciliation between the strictly medical, factual position on ulcerative colitis (etc.) and the apparently incompatible psychosexual hypotheses,

The themes and reactions stimulated in the minds of observers of ulcerative colitis are not simply irrelevant products of the human imagination; they are actually important elements of the patient's world. Although they are not components of the disease process *per se*, they are a vital part of the experience of being ill with this disease. This latter is true in that these themes inevitably affect the attitudes and behavior towards the patient on the part of those by whom he is surrounded.

Considered in communication terms, the process would be as follows: a symptom (diarrhea) develops; this symptom is observed by the patient's environment (wife, husband, doctor, etc.); the wife, etc. interpret this symptom in symbolic and personal terms; a misinterpretation develops about the patient's attitude and motivation; this misinterpretation then colors the environment's relationship with the patient, and consequently, becomes an element of the world in which the patient must live. The patient receives messages from the environment based on this premise, and he, in his

turn, reacts to these—often with a reinforcing message. The interpretation of the wife, etc. is an incorrect interpretation. However, it exists and, consequently, exerts an influence on the patient, who infers to some degree that that is how he feels—that is the way the message was interpreted.

If carefully studied, the psychosexual hypotheses can provide useful information about the experience of being ill. They can also be of value to the clinician treating illness, both from the standpoint of informing him as to environmental factors contributing to his patients' circumstances, and also informing him as to reactions in his own psychology that can influence his attitude towards his patient and thus affect the treatment program.

Illness is certainly more than disease processes. The disease processes are the physical reality of the illness. But the attitude of a patient's wife or husband towards the patient and his symptoms will have important repercussions on his general morale and emotional state and, consequently, on those psychological factors which affect so intensely the course of an illness, the occurrence of complications, the response to treatment. And similarly, the clinician need consider that his reaction to the patient and the patient's symptoms can significantly influence the course of the illness, the response to treatment, the cooperation of the patient with treatment procedures. When a pebble is tossed into the pool, ripples are sent out in all directions. Illness is an experience with many aspects.

In this fact is found the point that reconciles the medical facts with the repudiated hypotheses. The two are in this context associated, not as conflicting alternatives but rather as complementary information about illness. They comple-

ment each other, add to provide the much fuller picture of the experience of illness.

The only too common temptation to contrast physical with psychological on an internal-external axis ("inside the body" vs. "environment") leads to one final consideration. This consideration makes spurious the internal-external axis. Just as we recognize that messages are stimulated in the patient's environment by his symptoms, it is also clear that these symptoms can stimulate associations in himself. The communication process is not only one emanating to external observers. It is also affecting the patient's picture of himself—and contributing to the disease process in this circuitous but powerful fashion.

The patient is as prone as his wife or physician to project certain symbolic interpretations of his symptoms. Such interpretations—illuminated by the psychosexual hypotheses—create messages to the patient about his general circumstances, about himself. He reacts to these messages, fighting or accepting them; his psychologic state is thus altered. As a result, there then appear similar repercussions on his morale and his attitude about his illness and treatment as appeared in reaction to the attitudes of his wife, physician, etc.

A tentative flirtation with this viewpoint is found in the Alexander and in the Daniels material on ulcerative colitis. Alexander¹ wrote: "Patients suffering from diarrhea . . . often exploit this symptom emotionally for a symbolic expression of being exhausted, completely 'cleaned out,' and may use this symptom as a symbolic expression of castration. . . . The fantasy of eliminating an incorporated, dangerous, bad

mother is probably a secondary utilization of the symptom for unconscious emotional needs rather than the cause of it. The causative psychodynamic factors are probably much more elementary and less conceptual in nature." But then he returns, without further comment, to the psychosexual viewpoint of diarrhea as "giving a gift or carrying out an accomplishment, or as an accomplishment" or as "aggressive hostile" behavior.

Daniels⁷ wrote: "The second important factor common to these cases was the peculiarly intense effect upon their psychological adaptation of the *meaning* [sic] of the physical symptoms; that is, of the subjective perception of severe physiological disturbance." And⁸ ". . . the stool takes on a host of adventitious primitive meanings determined by the immediate motivations of the patients. When these archaic ideas of receiving or inflicting violence were unconsciously projected on an external agency, they resembled the operations of the paranoid schizophrenic."

A description of altered self-perception and its consequences is found in an article by Orbach and Tallent¹¹ concerning post colostomy patients. "All of the 48 patients who participated in the . . . investigation expressed the opinion that their bodily form had been altered in a way destructive to their physical appearance. The existence of the above opinion was reflected in a modified perceived body and body concept." ". . . the [altered] conception of one's body . . . produces a variety of protective measures to maintain the endangered structure, it also results in the reduction of many valued life activities. . . . The secondary change in body concept is paralleled by pervasive alterations of personal and social identity concepts.

The reduction of function and relinquishment of roles require a radical revision of how a person conceives his relationship to himself and to other people."

In an article¹³ which illustrates in a somewhat extreme way the above idea, a case of recurrent pharyngitis and cervical lymphadenopathy was reported. The patient was quoted as commenting about her disease, "I had these two huge glands in my neck. They were like testicles," and further, "that is what I was struggling with all week—the idea of being a man vs. being a woman."

The particular messages stimulated in this patient's mind by her enlarged cervical lymph nodes were naturally products of her total background, as were her interpretations of these messages and their implications—all of which occurred in the context of being "a psychoanalytic patient." The original enlargement of the glands was not a specific product of this background. It was a part of a complex biologic stress reaction to infection and concomitants. But the association was established in the patient's mind between testicles and the glands in her neck, under the influences of this multifaceted background. Thereafter, each awareness of the enlarged glands served to reinforce the unconscious association—until the moment of insight came to free her from this trap. It is possible, in addition, that these associations, with her resultant conflicts, subsequently contributed to the persistence of the enlargement of the glands—through autonomic channels. Hypnosis may be sometimes used as a technique of implementing the operation of these channels. However, anyone who has explored this aspect of hypnosis knows that elaborate procedure is essential and

that there are definite limitations, both in reference to time duration and intensity, to the extent of psychosomatic intervention.

It could be questioned at this point, in regard to the operation of autonomic channels, doesn't this put us right back with the psychosexual hypotheses, in the sense that a circuit has been closed? The patient has a symptom; the symptom comes to mean something to the patient (enlarged nodes=testicles); the association then reinforces the symptom; the symptom then depends on the presence of the association.

Such thinking revives the Aristotelian confusion of cause with logic. In another place,⁴ I describe how this confusion can obscure understanding of feedback circuits. For instance, in the pituitary-adrenal cortex circuit, the pituitary secretes adrenal cortex stimulating chemicals. The bloodstream level of the adrenal cortex products, in turn, influences the magnitude of the secretion of the pituitary chemicals. In Aristotelian terms, the one is a premise for the other and a circular relationship appears to present itself. However, this is revealed to be a confusion by remembering that Time is involved. The relationship is thus recognized as a linear, rather than circular, one. The pituitary product that influences the adrenal cortex production is not the same one that is subsequently influenced in production by the level of adrenal cortex hormone.

Similarly, the reactions that are stimulated by self-perceptions are recognized as nonetiologic in disease, as secondary complications of the disease process. This avoidance of Aristotelian confusion is assisted by remembering that, at the moment of insight (enlarged

nodes=testicles), the association is broken but symptoms remain. This persistence of the symptom is true, unhappily, in so many of the psychosomatic conditions. It is related, of course, to the observation by Fullerton et al. of the multiplicity of other previous psychosomatic ailments in their ulcerative colitis patients.

To return to the main thesis, we find that the patient is influenced by the internal communication of his own associations to his symptoms. His illness, in the broad sense, is thus complicated by an additional factor—the patient's picture of himself, and its various repercussions.

By virtue of the above considerations, the psychosexual hypotheses take on new significance. They illuminate what the patient is meeting in his environment. Misinterpretations are made of the meaning (in communicational, not medical, terms) of symptoms of illness by spouse, by physician, etc. These misinterpretations affect the behavior and attitudes to the patient of these important people. They thus become significant elements of his environment and, through this factor and through his response to it, become significant elements of his general condition. These hypotheses also illuminate the misinterpretations to which the patient himself is prone. These elements of self-concept contribute to the patient's general condi-

tion and need be considered for any complete understanding of his illness.

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Brief Communication:

A DIDACTIC APPROACH TO STRUCTURE IN SHORT-TERM GROUP THERAPY

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This brief paper describes an attempt to increase structure in short-term groups with parents of first-borns through the preplanned, didactic communication of information relevant to the common presenting problem of all the group members.

In theoretical papers on the subject of short-term therapy much is made of the concept of structure. Generally, the term refers to a variety of techniques that make for greater specificity of problems treated, clearer direction in the therapeutic process, and more exact treatment goals. In their recent book Phillips and Weiner⁵ argue that increased structure not only does not violate the uniqueness of the individual, as is often asserted by proponents of long-term therapies, but rather makes the therapeutic situation more satisfying for both patient and therapist and also provides a better basis for mutual problem-solving. In an earlier article Phillips and Johnston⁴ state, "Seemingly, man finds it necessary to

structure vague, formless, rootless experiences, so that he is better able to cope with them."

In conceptualizing short-term therapy Phillips and Weiner⁵ lay emphasis on the importance of precise, carefully planned communication as a means to increased structure and hence to efficient behavior modification. Along this line they advocate, among other things, detailed delineation of current problems, rational communication between therapist and patient, and programming of successive steps in the proposed change plan.

The use of didactic techniques in group therapy is not without precedent. Some of the earliest methods employed

a classroom model in which the therapist lectured for part of each meeting.^{3, 6} While the authors of these methods mentioned a variety of associated factors as being important to the success of their methods (appealing to the group members' emotions rather than reasoning by argument; stimulating mutual assistance among members; minimizing the stigmatic connotations of the material), they emphasized the classroom aspect as the central therapeutic tool. The treatment described here differs from these earlier methods in that the didactic technique is employed within a modern dynamic-interactional group setting. Also, the present treatment involves two related therapeutic goals: (1) the didactic treatment of the common problem, and (2) the dynamic short-term treatment of the unique problems of each person or couple.

THE COMMON PROBLEM

The common problem to which the didactic technique has thus far addressed itself is that of the first-born child. All couples selected for the groups have applied to the clinic for help with their first-born. The decision to form a series of groups around this common problem grew out of a previous study done by Shrader and Leventhal⁸ on the relation between children's birth order and number of parent-reported problems. In that study it was found that the number of parent-reported problems differed significantly for first-born, middle- and last-born children, with first-borns having more than either of the other two groups. Additional findings in that study were that first-borns come to the clinic more frequently than do the other groups, and also that young mothers report more problems than do older mothers.

Of particular import to the groups under discussion here is the fact, mentioned repeatedly in the birth-order literature^{1, 2, 7} and reflected in Shrader and Leventhal's data, that younger parents, especially with first-borns, tend to have excessive anxiety about their children, expect too much of them, and hence treat them with a combination of inconsistency, immoderacy, and excessive interference (these attitudes and activities forming what might be called the over-anxious, overexpectant parental syndrome). Since such a parental syndrome can be seen as harmful to children's development, and since it is most apt to apply with first-borns, this generalization comprises the core of the didactic treatment. The group members are repeatedly reminded of this syndrome, urged to examine their own child-rearing practices for evidence of it, and instructed as to how it might be counteracted in instances where it appears to apply. While other facts and generalizations from the birth-order literature are also used didactically, their purpose is primarily to supplement and reinforce this central theme.

METHOD

Birth order of the index child and natural mother's age are the two selection criteria about which the groups, consisting of five couples each, are formed. As mentioned above, all couples in the groups have come to the clinic because of their first-born child. In addition, because the overexpectant, over-anxious syndrome occurs more frequently among young parents, in all cases selected for the treatment the mothers are no older than 30 years of age. Rounding out the group composition are two co-therapists.

Each couple is seen a total of seven times, twice individually and five times in the group. The initial interview, in which each set of parents and child are seen as a family unit by one of the co-therapists, is essentially evaluative in nature. Following the initial interview the parents are seen in the group once a week for five weeks; and the child is seen five times individually by one of the therapists. In the final interview each set of parents is again seen individually by both therapists. This interview has a summing up function; it provides the therapists with the opportunity to reinforce the didactic theme, and to summarize their impressions and recommendations concerning the unique problems of the family in question.

As a supplement to the verbal communications in the group sessions, a written summary of the major research findings on first-borns is given to each couple in the final interview. This material, which has been carefully selected and prepared for lay consumption, emphasizes a number of points concerning the tendency for parents of first-borns to worry too much about their children, as well as some of the personality and behavioral factors that occur among first-borns.

In addition to the dissemination of information on first-born children, the didactic aspect of the treatment involves a number of related techniques. These are essentially supportive in nature, and they are aimed at counteracting the over-anxious, overexpectant syndrome whenever it is seen to operate among the group members. Consistent support and reassurance are used against the tendency to overanxiousness. With regard to the tendency to expect too much, the group members are consistently urged

to relax both on themselves and their children. In the interest of bolstering the impact of these remarks, an element of authoritativeness is purposely injected; that is, such communications by the therapists are liberally interlaced with references to the scientific literature.

A constant effort is made to apply these didactic-supportive measures to specific, concrete incidents. Thus, when a parent expresses worry or dissatisfaction about a child, he (she) is asked to specify the child's behavior as well as his (her) exact attitudes toward and expectations about it. In this way it is possible to determine in a variety of concrete circumstances whether or not the parents are actually worrying too much and expecting too much, and if they are, to attempt to teach them specific other expectancies and attitudes.

Despite the didactic emphasis, the treatment is carried out within the setting of what Sundberg and Tyler⁹ refer to as a free-interaction group. The classroom format is completely deemphasized, and the free, spontaneous expression of ideas and feelings by the group members is encouraged. Under this format it is possible to treat problems unique to each couple or member as well as the group's common problem. For the unique problems the more standard group therapeutic techniques (reflections of feeling, confrontations, and interpretations) are employed.

The five individual sessions with the children are used for purposes of evaluation and supplementation of the group treatment. In making a thorough assessment of each child, the therapists are able to gauge the accuracy of the parent's descriptions and hence the degree to which the parent syndrome applies. Supplementation of the group treatment

works in two ways. On the one hand, specific incidents occurring in the individual sessions are used both to illustrate and to modify the syndrome. On the other hand, communications made to the parents in the group are supplemented by parallel communications made to the children.

DISCUSSION

As a method of short-term group therapy the approach described here would seem to have wide applicability. Any number of problems pertaining to children, adolescents, and adults can conceivably be treated by similar didactic techniques used in a free-interactive group setting. The essentials of the approach consist of (1) a relatively homogeneous group of patients seeking help with a common problem and (2) a carefully prepared body of information relevant to the problem. Efficiency, clarity of goals and direction, and an atmosphere of positive problem-solving in the group process are all facilitated by the didactic technique and the homogeneity of the group composition.

In addition to the didactic treatment of the common problem, the free-interactive group setting facilitates the detection and secondary treatment of problems related to the common one but unique to each group member. In treating the individual problems it is possible to use a variety of techniques such as ventilation, confrontation, and interpretation that are commonly associated with modern dynamic therapies. While the secondary dynamic aspect is limited to the handling of conscious and preconscious factors in the group member's personalities—aimed essentially at ego modification—it provides a treatment

dimension that a more rigorous classroom format would presumably lack.

As mentioned above, this approach can be applied to many problems. In a child guidance setting such problems as school phobia, enuresis, adolescent rebellion, academic underachievement, minimal brain dysfunction, juvenile delinquency, etc. could be similarly treated. In a comprehensive community mental health setting the list of potentially treatable problems would seem to be without limit.

Thus far we have outcome data on only one group of parents of first-borns. However, these preliminary results have been interesting and encouraging. Both quantitative indices (differences in number of children's problems indicated by the parents on a checklist immediately before and six weeks after treatment) and qualitative impressions (recorded in a followup group session eight weeks after treatment) suggest definite improvement in the index children's adjustment. When sufficient data from subsequent groups have been collected, a more definitive report will be forthcoming.

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DELIVERY OF SERVICES

CLINICAL SERVICES TO THE AGED WITH SPECIAL REFERENCE TO FAMILY STUDY

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Patterns of clinical services, both for the individual in the community and for the institutionalized, are described. Emphasis is placed upon a team approach, which involves close interdisciplinary cooperation. Staff effectiveness is enhanced by orientation as an integral part of psychiatric services. Family study and involvement are essential to diagnosis and therapy.

The mobilization of effort that is taking place to meet the challenge of our aging population is amply attested to by the ferment of activity that is taking place at all levels in the community—legislative, political, professional. The range of problems to be met, and of services that may be rendered, is so wide that we have restricted this discussion to those patterns of clinical service involving collaboration between medicine (particularly psychiatry and internal medicine) and the other health professions.

It is in the field of geriatrics that the closest cooperation between the various disciplines is essential, since problems in the aged generally represent the outcome of a complex interaction between organic changes and modification of interpersonal and social relationships, as well as the reactivation of old neurotic conflicts. Since stresses tend to be cumulative in their effects, the definitions of stress at different levels and their integration into a pattern of causation is of primary significance. Only by delineating the different patterns of stress in older

people, as well as the resources of the individual, will a comprehensive picture of etiology and a rational plan for management be possible.

COMMUNITY-BASED SERVICES

The areas of service to the aged may be conveniently divided into those that are community-based and those that are based upon work in institutions. In the community, the leading role in establishing a coordinated approach to the problems of the aged has been undertaken by family agencies, which seek consultation with internists and psychiatrists for purposes of establishing diagnosis and cooperating in management. Experience with such consultation work indicates the importance of assessing degree of brain damage, with special reference to minor aphasic disturbances, and detection of depressive trends, often hidden in the aged under a blanket of somatic complaints.

Decisions regarding patterns of sheltered care require an evaluation of rehabilitation potential, significant personality deviations, and family resources, all of which require cooperative study by the specialties involved. Home visits have been used as a diagnostic procedure for this. In a number of instances, the appropriate medical consultation has been carried out by the internist at home in the presence of various members of the family and the caseworker, thus affording an opportunity to observe the patient in his own environment and to note the pattern of family interaction.

The need for a team approach has led to the development of specialized geriatric clinics or comprehensive care clinics attached to general hospitals or to homes for the aged. In such clin-

ics, the elderly patient is no longer regarded as a bothersome intruder with vague complaints and a thick chart to burden the attending staff. His needs for specific diagnosis and management, for fulfillment of dependency expectations, for realistic solution to significant physical, social, and personal problems, are focused upon. The initial emphasis in such clinics may be upon the general medical, rehabilitation, or psychiatric aspects of the client's presenting problem, but in every case there is effort to establish diagnoses and a therapeutic approach based on coordinated study by the physician, psychiatrist, psychologist, and caseworker. Families are involved, both as resources and as sources of stress for the patient. The results have been gratifying, and point to the need for extension of this type of service, as well as for further education of the medical profession in meeting the needs of the aged.⁴

With the growth of the community approach in psychiatry, there has evolved the concept of a community evaluation center which could provide integrated services at all levels for diagnosis and treatment, including, on a more ambitious plane, short-term hospitalization for day or residential treatment. At the Jewish Home and Hospital for Aged such an evaluation center is in the planning stage. At such a center, elderly individuals and referring agencies will be able to obtain comprehensive evaluations for purposes of treatment and planning. Existing extramural care programs and provision for inpatient care will be coordinated as facilities become available. The need for such centers has been particularly emphasized in surveys from the public health point of view, as in the WHO¹¹

report on problems of the aging and Cohen's² report for the U. S. Senate.

INSTITUTIONAL CARE

About 4% of the aged are in institutions, but their care requires a great deal in resources—financial, technical, and personal. Institutional treatment has become increasingly expensive as standards of care have risen and the mental and physical deficits of patients have become more pronounced. The last decade has witnessed a converging trend in population patterns between nursing homes and homes for the aged. But with the development of care services in the community, admission to an institution now is based on considerable loss of functioning ability, so that increasingly complex problems of nursing care and other forms of assistance within institutions are to be anticipated.

In view of the limited time usually available to them, psychiatrists with experience in institutions have generally agreed that a significant proportion of psychiatric time should be devoted to staff training rather than to direct psychotherapeutic service.^{5, 7, 8} Such training provides a background for an appropriate psychotherapeutic orientation by the total environment, as well as for the multidisciplinary approach considered essential. A continuous pattern of psychiatric service is desirable, rather than one limited to emergencies and commitment procedures. The continuous pattern should include, along with the examination of occasional patients requiring diagnosis and management, a regular schedule of staff orientation.

Staff of all levels need to be involved in the training, both in separate groups and in joint meetings. The joint sessions aid in establishing communication be-

tween different levels of staff and in promoting a sense of participation among nursing aides and attendants, who play a crucial role in daily care. In the conferences with separate groups, specific problems can be discussed at an appropriate level. We have found it especially important to reach the aides and attendants, who operate under difficult conditions personally and professionally. Through separate conferences, free from the presence of supervisors and administrative personnel, attempts have been made to reach their anxieties and countertransference patterns, and to offer support in this area. Extensive reorientation has been found necessary with regard to the acknowledgement of countertransference attitudes. We usually find that the denial of anxiety and the assumption of complete objectivity are considered as desirable traits in the interaction between staff and residents.

Conferences need also to be held with boards of trustees of institutions, to help them crystallize an appreciation of trends in nursing home populations and define values in the programs offered residents. For therapy, the management of paranoid and aggressive patients is often focused upon treatment of staff rather than upon the patients, who in view of their limited resources often cannot change significantly.

While the provision of such psychiatric services can be implemented in large voluntary homes for the aged, the question arises whether this pattern of psychiatric care can be effected in smaller homes or in proprietary institutions, where budgetary considerations and staff limitations may offer serious obstacles. The experiences of the Protestant Welfare Federation of New York are worth noting. In 1960 a pilot proj-

ect was inaugurated involving systematic psychiatric services to three small homes for the aged, one of them a chronic nursing home. Psychiatric services consisted of one session a month, which was occasionally a diagnostic visit with specific management recommendations but more frequently was a discussion of problem patients with the entire staff. These discussions provided a springboard for a general understanding of disturbed behavior along dynamic lines. The results of the program were most favorable. The staff became more comfortable in handling disturbed patients, less prone to refer to mental hospitals, able to cope with a wider variety of disturbed behavior patterns. After a year of this pilot project, each of the institutions decided to continue this type of service as an independent activity. The favorable modifications in institutional atmosphere and staff attitudes have continued.

At the Jewish Home and Hospital for Aged, regular departmental conferences provide a basis for collaborative study of patient problems. Questions arising during the course of intake about a patient's suitability from a psychiatric point of view are resolved by referrals for psychiatric screening. If the applicant is admitted, appropriate followup studies are undertaken. The availability of psychiatric resources has made it possible to undertake a more liberal attitude regarding the admission of disturbed individuals or those with a history of psychiatric illness.

ROLE OF THE FAMILY

A crucial experience for the old person who must be institutionalized, for his family, and for the staff is the initial period after admission.¹ There is a

marked exacerbation of anxiety in many instances, both on the part of the patient and family. This can result in the precipitation of any of the common psychiatric syndromes, marked reduction of level of function due to chronic brain syndrome, or the aggravation of symptoms in a chronic medical condition. With understanding and appropriate management, the clinical disorder can be handled in most instances. Participation of the family is required and interpretation must be offered them. Individual counseling and group counseling for families are important adjuncts at this important phase of institutional adjustment. Where difficult attitudes persist on the part of the family, the psychiatrist may be of assistance in offering interpretations on a "medical" level.² The authority of the physician and the acceptability of a medical explanation can mitigate some of the family anxieties and permit further clinical progress on the part of the patient. In fact, the participation of the psychiatric department can be helpful in the handling of many administrative problems such as room placement, classification, and disposition, particularly if the focus is not only upon management procedures but upon the development of staff attitudes and their impact on the patients.

Among the significant stresses faced by the aged are those involving patterns of family interaction. The regressions induced by losses in adaptive capacities, including chronic brain syndrome, as well as by the realistic aspects of the dependency relationship to children reinforce patterns of mutual dependency and can reactivate parent-child and sibling relationships long dormant. This "role reversal"³ is compounded, at least under pathologic conditions, by

the reactivation of childhood fantasies of the reversal of generations.⁸ We have been impressed by the sensitivities of our elderly patients to details of family relationships and by the role family interaction plays in the precipitation of disturbed behavior, fluctuations in chronic disorders, and disability incident to chronic disease. We therefore consider systematic exploration of the family situation essential at all points of contact with an elderly client.

The long-term relationship to staff in the institution also assumes the pattern of a family relationship. Details of nursing care of the elderly resident often duplicate, in literal fashion, the physical aspects of the mother-child relationship. The family situation is often represented in the staff-patient interaction, directly or by displacement from current family experiences. This adds to the emotional burdens of the staff. Staff anxieties undermine tolerance for deviant behavior and may lead to abrupt or punitive attitudes, with consequent deterioration of the ward atmosphere. The burden often falls most heavily on the individuals least able to bear it, the attendants and aides. Continued education and support are necessary, as is a reevaluation of the central role they play in nursing care.

Family study may take the form of home visiting, family interviews, intensive work with individual family members or significant staff members, and sessions for family members to give them orientation to problems of institutional living. Changes in status or shifts in behavior on the part of an elderly patient call for an exploration of the family context and, frequently, for participation by family members in the pattern of treatment. Systematic family

therapy has not yet been applied in our own institution due to limitations of staff time. It is one of the projects we hope to attempt in the future.

SUMMARY

This brief descriptive survey has attempted to underline the need for an integrated approach to the emotional problems of the aging. We have noted how closely interrelated are the physical, mental, and emotional disturbances in the elderly, how vulnerable our clients are to a wide range of stressful circumstances. The long-term relationships involved in nursing care necessitate a continuous program of staff orientation and discussion of difficult situations. Detailed studies of family interaction have revealed significant sensitivities, and have provided valuable clues to the understanding and management of disturbed behavior. The team approach is fundamental to adequate service to the aging, both in the institution and in the community.

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THE JOB CORPS AS A COMMUNITY MENTAL HEALTH CHALLENGE

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This paper describes the development over two years of a model for comprehensive mental health services in a non-health care agency, represented here by the Job Corps as a case in point.

Psychiatry, like many other related disciplines today, is turning increasingly toward "the community" as a source of support and strength.^{8, 9, 23, 25} The development of the community mental health center is a part of this process, as is the recognition of the role which agencies whose primary job is other than the delivery of direct health care can play in implementing programs of prevention and rehabilitation. The de-

velopment of preventive mental health services within agencies of this type is a challenging but thus far underexplored field. Until very recently, the majority of these programs were located in schools, colleges, and occasionally correctional facilities²⁰⁻²² (although only rarely did they include elements designed to promote psychological growth as well as prevent psychiatric illness). The military has also had a long-standing interest

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in community mental health programs,¹⁰ and among Federal civilian groups the Peace Corps has been preeminent as a non-health care agency having an enduring interest in, and concern with, the mental health of its program participants (volunteers) and their maturation and development.^{5-7, 11}

We have discussed elsewhere a number of the specific components comprising the Job Corps Mental Health Program.¹³⁻¹⁶ Our purpose here is to describe the challenges with regard to technique and theory that are presented to the psychiatrist who wishes to implement a successful comprehensive program—of direct mental health services, preventive services, and indirect services supporting and promoting psychological growth—within an agency as vast and as distant in its primary objective from health as the Job Corps. We will present selected aspects, greatly condensed, of two years of data drawn from our actual daily work experience. We focus on the Job Corps as a prototype of the agency which is large, which does not define its goals in terms of health or mental health, but which has the opportunity to affect, positively or adversely, the mental health of large numbers of program participants.

PROBLEM

The Job Corps is the only national residential training program for disadvantaged adolescents. It was developed to increase, through training, the employability of these low-income youngsters. This goal requires an integrated program designed to foster the kinds of skills (vocational, educational, and psychosocial) which are prerequisites for employment in a complex society. The challenge this presents is

not inconsiderable when viewed in the light of the educational, psychological, and social deficits which youngsters from poverty present.^{13, 15}

MENTAL HEALTH PROGRAM

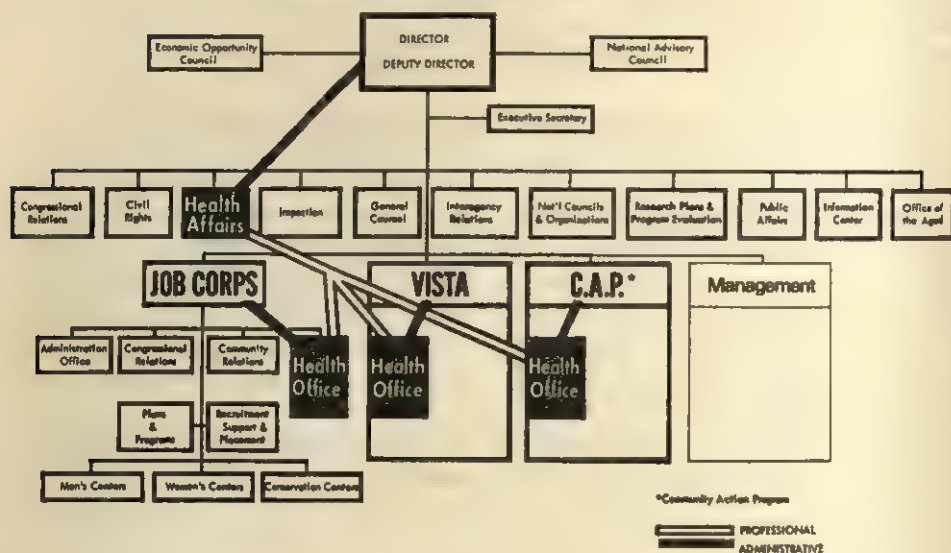
The Job Corps mental health program has been geared to meet the needs of the youngsters and the agency which serves them. The evolution of the program has involved a conscious attempt to be responsive to these needs, as we perceived them, at each level of agency operation (national headquarters, regional, and field). This has required a process of repeated reevaluation of the agency's needs, since these often changed rapidly.

1. *National Headquarters:* From the earliest days of our involvement with the agency, initially as consultants, it seemed clear that Job Corps would require a full-time formal in-agency health office.¹ It was also clear that a comprehensive mental health program could gain acceptance only as a part of a general health program.

The Job Corps health office was established in August 1966, and was made responsible administratively to the director of the Job Corps and professionally to the assistant director of the Office of Economic Opportunity for Health Affairs (FIGURE 1). The health office is responsible for all aspects of health throughout the entire agency. It is responsible for ensuring that Job Corps members who become ill are afforded health care of high quality; for medical (including psychiatric) termination and referral to hometown facilities of those too ill to benefit from Job Corps training; and for supervision of medical screening during the preenrollment period. The agency was initially willing to

Figure 1

OFFICE OF ECONOMIC OPPORTUNITY Executive Office of the President



accept the health office on the basis of wishing to have, within the Job Corps, a focus of clinical responsibility for corpsmembers who became ill.

From the outset, we felt that the Job Corps (which at the time saw itself primarily as a skill training program) had considerable potential for affecting the psychological and social development of corpsmembers. In addition, we felt that many of the adjustment problems of corpsmembers could be effectively dealt with in the Job Corps to the ultimate benefit of the youngster. We were convinced that "preventive" psychiatric techniques could be adapted to the Job Corps setting, thereby extending the impact of a small number of mental health professionals working in the program. With these objectives in mind, we negotiated with the Job Corps

not only for clearcut responsibility for clinically ill corpsmembers, but also for a mandate making us responsible for "all health and mental health affairs in Job Corps."

The nature of this agreement established us as *responsible* executives within the organization rather than as more conventional consultants. At first, our assistance was sought only with individual youngsters presenting specific problems. These problems were initially of two main types—aggressive behavior and psychosis. As we responded to these requests for help, we tried also to begin placing each individual problem in the context of the broader mental health issues which it raised. These issues included such matters as the psychology of failure, of crisis, of stress, and of situational variables; staff and program

difficulties; inadequate preparation of youngsters for admission to Centers; overly authoritarian or completely permissive discipline.

As these problem areas became better delineated, it was possible to design specific interventions to deal with them, based in large measure on our own work and experience with corpsmembers at Centers. The interventions ranged from policy statements on preventive mental health through the design of programs of crisis intervention; from educating staff members about the value of firm consistent limit setting through assistance in developing greater integration of basic education, vocational training, and counseling; and from modifying policies in many program areas through participation in staff training. The plans and programs we developed spread through the system, sometimes as policy statements and sometimes as educational materials. Eventually, many were incorporated into a mental health program manual.¹⁴

As a point of departure, we chose to consider the problem of "dropout" from Centers since this was an obvious area of immediate concern to the agency. To address ourselves to this issue, it was necessary that we become intimately involved in the entire business of the screening of applicants, the preparation of potential enrollees, and the handling of initial reception and the early period of enrollment. This permitted us to deal as fellow-executives with those primarily responsible for operational aspects of the program at every level. As we worked along with these new colleagues in the collaborative effort to prevent premature termination, we had the opportunity to share some of the bases of our program ideas rooted in our knowledge

of the psychology of adolescence and in our thinking about what mental health professionals might contribute to the agency and to corpsmembers.

Our involvement with program staff has been an ever-increasing one. We now provide ongoing mental health expertise to each of the operational components within the Job Corps national headquarters. In this way, every program area becomes available as a potential site for mental health programing around issues including direct care services, consultation services, counseling and group living programs at Centers, screening of applicants and preparing them for the separation from home, and then later for support after graduation. As is true for other headquarters offices, it is mandatory that we concur with any new Job Corps policy or directive.

From the national level, we have attempted to implement our mandate and responsibility for mental health programs in the field utilizing a variety of techniques. This has proven, in many ways, to be our greatest challenge. In addition to adopting clearcut policy provisions regarding comprehensive mental health services at Centers, we have met with groups of Center directors, physicians, counselors, supervisory staff, and others to inform them about the potential contribution mental health services might make to their Centers. For this purpose, plans developed earlier to diminish the dropout rate have been particularly useful; so too have been programs of crisis intervention, developed as we explored periods of specific stress which all youngsters face during their Job Corps careers.

2. Regional Operations: In order to facilitate mental health program development in the field and to enhance

communication and feedback from field operations and Center staffs, we have found it useful to have medical and mental health consultants working in the OEO regional offices. These consultants also assist us in the difficult task of implementing headquarters policy and program in the area of mental health and in integrating our knowledge of problems at Centers with regional problems and ultimately with national program problems.

3. Field Operations: In addition to our work in the headquarters and regional offices, it was clear that to fulfill our responsibility for the mental health of corpsmembers we needed to ensure that Centers would in fact develop comprehensive mental health programs that included modalities of consultation, staff training in mental health skills and knowledge, and crisis intervention. Although many Centers had arranged for at least emergency services during their early days,¹⁵ it was not until June 1967 that official Job Corps policy actually dictated that corpsmembers must receive diagnostic and evaluation services, including hospitalization when necessary. Job Corps also now provides short-term treatment, including drug, supportive, and psychotherapeutic services for corpsmembers at Centers.

The number and variety of preventive mental health programs at Centers have increased dramatically since the early days of Job Corps in spite of the very remote location of some rural centers.¹⁶ Ingenious arrangements for consultation services have been worked out locally: flying consultants, consultation to clusters of rural Centers, intermittent on-Center consultation programs, and telephone consultation services. We have previously reported our own experience

in mental health consultation at two Job Corps Centers,¹⁸ and the experiences of other consultants have also been reported.¹⁶

Each Job Corps Center is a community in microcosm. Each is unique and for each the local mental health resources differ considerably. Thus programs are bound to differ from Center to Center. Yet, keeping this in mind, we have built upon early Job Corps experience and our own work at Centers to develop a widely applicable Job Corps mental health program. This program is designed to assist Centers in developing an integrated plan, encompassing every component of Center life, for fostering positive adjustment and constructive psychological growth. The mental health consultant is utilized to assist the staff in early case detection, crisis intervention, staff training, programming, brief treatment, and followup. This involves the center mental health consultant in various functions:⁴

1. Direct services—diagnosis and treatment.

2. Indirect services—(a) Consultation with the center director, center physician and health staff, counseling staff, resident workers, teachers, and supervisors. Under appropriate circumstances, the consultation may focus on individual enrollees, on Centerwide problem areas (e.g. discipline, work attitudes), on administrative or program issues, or on all three. (b) Staff training in mental health. In the Job Corps setting, staff training and consultation are closely related since many of the staff are untrained in the field of mental health. Staff training may be in the area of recognition of early signs of mental illness, or in technical skills of interviewing and working with youngsters. (c) Mental health pro-

gram planning. The consultant assists the Center in developing a comprehensive mental health program adapted to its needs, including elements designed to help enrollees through the normal "crises" of arrival, engagement, and graduation.¹⁴

Over 150 mental health professionals (psychiatrists, psychologists, and psychiatric social workers) have assisted at the Centers in both direct and indirect services.¹⁶

We have extended the range of the mental health program to include screening agencies. Our concern, in addition to the direct selection of enrollees, has been with preparing youngsters to enter the Centers more effectively. In some measure we have added anticipatory guidance to the entry process. We have developed pilot experiments which include mental health consultation to screening agencies coupled with emotional support for families of Job Corps members to whom the departure of a child may represent a serious life crisis. The range of mental health activities has also included development of a model for consultation services for postgraduation support programs, as well as active headquarters involvement with the establishment of a national volunteer program which provides support and placement for graduates.

DISCUSSION AND CONCLUSIONS

The work we have described within the Job Corps setting raises a number of empirical and theoretical questions. The Job Corps is a large and highly complex community. As Rafferty¹⁹ has pointed out, in such a setting "the psychiatrist who becomes a consultant and confidante of policy and decision-making people frequently can influence or-

ganization, decisions, and values so that noxious effects of the community are decreased and supportive elements are increased." However, our approach to the Job Corps is not that of the usual consultant to an agency.⁸ Based on our experience with other agencies^{6, 22} and on our initial diagnosis of the Job Corps as a social system, we felt that we had to function as responsible executives within the agency much as any executive functions within any organization. In a number of settings, for example the community mental health center, psychiatrists assume what Levinson and Klerman¹² have called the "clinician-executive" role. The critical difference in our work is that Job Corps is not a health care agency and thus does not fall within the usual purview of the clinician-executive.

Further, the role of the clinician-executive is different in this kind of agency. The Job Corps recognized that it needed clinicians to take responsibility for the care of those individuals who became ill while in the Corps. We offered to accept that responsibility within the broader context of assuming executive responsibility for all aspects of health and mental health affairs. This combined clinical and program responsibility provided our entry into the agency, and has supplied us with ongoing sanction and a base from which to work. The blending of clinical and programmatic responsibilities was made possible by virtue of our role as physicians and as mental health specialists forming a part of a comprehensive health team. To implement the mandate provided us by the director, we have had to repeatedly negotiate at all levels of the system demonstrating our capac-

ity to deliver on our promises and commitments.

Although we had carefully established our office in such a way that we had the opportunity to assist in all aspects of the agency's functioning related to mental health, we found that initially we were perceived only as experts in mental illness. The problem of reconciling our skills and objectives (of introducing preventive psychiatric principles and programs and of assisting the Job Corps to recognize its potential as a phase-specific program for the psychological and social development of disadvantaged youth) with the Job Corps' initial view of what we could contribute, has required the work of the past two years.

The problem of altering our new associates' role perceptions of us has required an ongoing educational process. At times we have had to return to our written mandate to enforce our involvement in issues having broad mental health implications. Gradually, the understanding of our role has grown, allowing us readier access to all parts of the system. The delivery of services of high quality in the clinical areas has continued to form the base on which the remainder of the program is built. Were we to lose sight of this basic function, all else would soon topple.

Our work in the headquarters, however, would be fruitless without the field mental health programs, difficult as they have been to implement. They are the payoff, of course, for any programs centrally conceived. Thus, the mental health program in the Job Corps is designed to be flexible regarding the changing needs of Centers but responsive to our overall objectives. Mental health consultation, crisis intervention, and anticipatory guidance techniques have been

adapted to the particular needs of the Job Corps and its population. A program of this type, responsive to local Center conditions, cannot be achieved by fiat or by central office policy and program direction alone. It requires the effective coordination of individuals and program components not themselves subject to direct central authority.

The model we have presented may well be adaptable to other settings and other programs. These programs permit an extension of mental health practice from the community mental health center into the community proper. They present to the mental health professions increased opportunities and challenges.

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REVIEWS OF THE LITERATURE

MENTAL ILLNESS, DUE PROCESS AND THE CRIMINAL DEFENDANT

Association of the Bar of the City of New York:
Special Committee on the Study of Commitment
Procedures and the Law Relating to Incompetents

Bronx, N.Y.: Fordham University Press, 1968. 261
pp. \$5.95

The New York Times of May 1, 1964 reported that an individual, aged 30, arrested in Flatbush on April 24, 1905 for "theft of a horse, a buggy and a harness worth about \$125," and committed to Matteawan State Hospital on June 24, 1905 following a plea of not guilty and a lunacy commission finding of "acute delusional insanity," was released 59 years later at age 89 on a motion to dismiss the indictment because the patient "was no longer a menace to society or other patients." A staff psychiatrist reportedly noted that "in his younger days . . . he was somewhat violent, but recently he has been docile and cooperative." The patient was reportedly expected to be sent to a civil institution "for further treatment for schizophrenia."

An uneducated 19-year-old boy was arrested in 1901 and accused of committing burglary. Without ever receiving an opportunity to prove his innocence, at the age of 83 he had the distinction of being the patient longest in residence at Matteawan State Hospital. For 64 years the law had not only denied him a speedy trial or periodic review of his condition, but had confined him for a period many many times longer than had he been found guilty, in what for many years was an overcrowded and understaffed state correctional institution. There was no indication that the indictment against him had

ever been dismissed, so that theoretically he was, at age 64, still subject to being placed on trial if he should have recovered.

These two cases are illustrative of the circumstances which give rise to this report, *Mental Illness, Due Process and the Criminal Defendant*, which is an outgrowth of the same committee's earlier report *Mental Illness and Due Process* reviewed in the January 1964 issue of the JOURNAL. The earlier report was concerned with the hospitalization of the mentally ill in civil institutions and led to the full-scale 1965 revision of New York's laws governing the same. This report covers the hospitalization at Matteawan State Hospital and Dannemora State Hospital, two mental hospitals operated and staffed by the State Department of Correction for five principal categories of persons: (1) prisoners serving sentences; (2) prisoners whose sentences have expired; (3) allegedly dangerously mentally ill civil patients transferred or committed from civil state hospitals; (4) defendants accused of crime who are found incompetent to stand trial (category of over 1,000 cases, including the two illustrative cases discussed above); and (5) persons acquitted of crime by reason of lack of criminal responsibility (insanity).

With respect to the first category, consisting of mentally ill prisoners serving sentences, the authors recommended that the procedures governing their hospitalization should be modified to provide such persons with some of the rights accorded to civil patients. The recommendations provide for notice of the application to hospitalize to be given to the Mental Health Information Service, with the Service having the same powers applicable to civil patients, including periodic review

with the assistance of the Mental Health Information Service. In place of the present statutory requirement of full recovery before the patient is returned to prison for the balance of his sentence, the recommendation substitutes a criterion that the patient "has recovered or has improved to the degree that he no longer requires hospitalization." The report also recommends the elimination of the present criterion for discharge in certain cases requiring that there be relatives or friends willing to maintain the discharged Matteawan patient without public charge and the adoption of a uniform standard for the discharge of any patient who is recovered or who is "no longer in need of hospitalization."

With respect to the *second* and *third* categories, consisting of prisoners whose sentences have expired and the allegedly dangerously mentally ill, the report recommends elimination of present provisions which authorize hospitalization of dangerously mentally ill patients at institutions within the Department of Correction and proposes hospitalization under appropriate conditions within the Department of Mental Hygiene. The bulk of the legislative recommendations applicable to this category were achieved by the unanimous decision of the United States Supreme Court on February 23, 1966 in the *Baxstrom* case holding that by reason of the equal protection clause of the Fourteenth Amendment a person who is civilly committed upon expiration of sentence (1) is entitled to the same jury-trial review of the commitment decision as is available to anyone else who is civilly committed, and (2) is entitled to the same judicial determination of dangerous mental illness as is required before any other civil patient can be hospitalized. The report includes as Appendix D, "Operation *Baxstrom* After One Year," written by representatives of the Department of Mental Hygiene. At the end of February 1967, of the 969 *Baxstrom* patients there had been 176 discharges, 147 of these to the community and the remainder to other hospitals, with 454 on voluntary or informal status. It had been anticipated by some officials that as many as one-fourth of the

Baxstrom patients might prove too dangerous for civil hospitals. As it worked out, only seven patients were found difficult enough to warrant committing them to Matteawan on a judicial determination that they were dangerous. Of those released, there was a record of only one subsequent arrest, and that for petit larceny. Since all the *Baxstrom* patients had prior to the *Baxstrom* decision been administratively rejected for civil hospital care on the basis of clinical judgment, there is need for concern about the reliability of the clinical judgment of dangerousness and ample warrant for the study of this category of deprivation of personal liberties now in process by the Roger Baldwin Foundation of the American Civil Liberties Union. Operation *Baxstrom* notes that "the potentially more dangerous character disorders tend to have transitory psychotic episodes which clear up . . . and those with more serious psychotic illness tend to settle into an amenable patient role under treatment," underscoring the need for special scrutiny of the diagnosis of dangerousness.

With respect to the *fourth* category, consisting of persons accused of crime whose mental condition precludes them from understanding those proceedings or assisting in their own defense, the report emphasizes the unfairness and prejudice of the present statutes, including the need for imposing maximum time limitations during which a prosecution may be suspended and the charges left hanging. Stressing the fact that the defendant, even when indicted, has merely been accused of a crime and is entitled to the same constitutional presumption of innocence afforded the mentally well, the report recommends that hospitalization should not be in a criminal or correctional institution and should not be mandatory. If an ordinary civil patient suffering the same type of disability would not be hospitalized the report sees no justification for hospitalizing the accused mentally ill. The report includes detailed recommendations covering the delay in prosecution achieving an excellent balance of rights and interests.

With respect to the *fifth* category of persons acquitted of crime by reason of

mental illness (criminal insanity), the report recommends an automatic and immediate examination as to his current mental condition. If he is determined to be in need of hospitalization, it should be accomplished by the procedures established for the hospitalization of ordinary civil patients covered in detail in the Committee's earlier report, and he should thereafter be treated for all purposes as a civil patient.

Like its predecessor, this report is a further step forward on the road, much of which remains to be traveled, toward equality for one of the too many unequally treated groups in our society.

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MODERN HUMANISTIC PSYCHOTHERAPY

Arthur Burton

San Francisco: Jossey-Bass, 1967. 171 pp. \$6.95

Book reviews should start with a frank statement of the reviewer's biases on the subject matter covered in the book. This is particularly so when a book attempts to present a theoretical approach to a field so filled with controversy as psychotherapy. Burton has written this book to place the "humanistic-existential conceptions of philosophy into a proper framework of psychotherapeutic science."

The reviewer classifies himself as a behaviorist who feels that most of the psychanalytic formulations which are basic to Burton's presentations have outlived whatever usefulness they may have had in the dim historical past. Further the reviewer feels that psychotherapists must strive to make their field a scientific endeavor rather than an artistic one, a view which is the reverse of the author's. Having put the cards on the table, with bias exposed, the question then is "What has the author attempted to achieve and how well has he done it?"

Burton has taken a series of his earlier published papers, edited or rewritten them and put them together to present what he calls an "extension of Sullivanian and Rogerian interpersonal conceptions" to modern cultural crises that confront man. Burton's goals are indeed ambitious, being no less than to describe current "humanistic/existential philosophical conceptions in an understandable way," and to then apply these concepts to psychological behavioral and psychiatric problems to present a "new and more useful understanding" of neurosis and psychosis and to present technical innovations in psychotherapy which can be applied to all theoretical orientations.

Burton calls this approach "being therapy" because it interprets neurotic and psychotic behavior as a way of being-in-the-world, or more correctly, as a way of non-being.

Burton starts with an introduction to humanistic psychotherapy which briefly presents his philosophy. He then offers three chapters on phenomenological aspects of therapy such as existence, time, and loneliness. The next six chapters go into some of the techniques involved in treatment such as transference, interruption of therapy, acting out, the use of artistic productions, touching the patient, and the fear of death as "countertransference." He concludes with two case histories of young women who have been labeled schizophrenic.

The theoretical material Burton offers includes acute observations on human behavior, cogent discussion of the meaning of life and death as it may be related to psychotherapy, and some obscure psychoanalytic and existential jargon. It is almost as if we have a man struggling to overcome a past which has become mordant as he strives for a new and clearer vision of his life's task. Burton's observations on human behavior, particularly that of the therapist, are excellent and would entitle him to the label of a good commonsense therapist if he, as so many other therapists, were not wedded to a theory of psychodynamics that simply has not paid off.

Among Burton's observations or conceptualizations of disturbed behavior which

this reviewer would find quite compatible and sensible are the following: "Schizophrenia is moving away from a medical model to a social model which is more descriptive." "Transference and countertransference are insufficient therapeutic formulations in themselves." "Insight is a necessary ingredient for the gratification of the therapist, but it does not necessarily stir the patient to action." "The time variable is an important one in psychotherapy and is usually neglected by the therapist. The modern psychotherapist is concerned with the patient's "interpersonal response" to psychotherapy and to the people in his world.

Such observations are representative of a therapist who has learned to deal with the here and the now of psychotherapy. He recognizes that he cannot cope with the individual seeking help in a vacuum divorced from his—the therapist's—values and meaning of life. He recognizes that he is working with behavior that has been labeled "good" and "bad" by the client and/or by his society. All the evidence in the book, especially in the two case studies, would point to the fact that Burton is a good therapist and a humane person (in fact, of course, the therapist cannot be one without being the other).

Yet Burton, as so many other modern psychotherapists, still clings to a terminology and conceptualization of man that is probably antithetical to his actual practice and techniques of changing human behavior. For example, he attributes many strange and, I think, contradictory attributes to the therapist: "Above all, the psychotherapist represents the unconscious part of the schizophrenic's conscious." "The psychotherapist becomes the patient's Other; he is himself, but he is also a significant unknown part of the patient." "Psychotherapy is a nonviolent, passive, feminine occupation." If the schizophrenic patient does not desire to touch the therapist during the course of treatment then psychotherapy is going badly (this is because schizophrenia by psychoanalytic definition involves regression to a "primary narcissism"). Psychotherapy is a "purification process in which the psychotherapist temporarily assumes the unre-

constructed parts of the patient for his later reconstruction and the patient introduces an illusion of his everloving psychotherapist . . . at an unconscious level." "Successful psychotherapists have high Eros/Thanatos quotients." The therapist is a "mother-surrogate." "Psychotherapy is a temporal coordinate of communal hours which congeals into an epic in the lives of both participants."

One could go on indefinitely taking quotations out of context. The intention is to communicate a very real hiatus now existing between theoretical terminology and practice in psychotherapy. Burton himself is aware of this as indicated by many comments throughout the book. It should be called to the attention of the humane existentialist that he is dealing with human behavior in an important and meaningful way and he should seriously consider switching his conceptual allegiance from the disease model of psychoanalysis to the educational model of the behaviorist.

Burton has done a commendable job of rewriting what were once separate papers into an integrated expression of a viewpoint, one which is still in transition and one which will probably continue to be a vital force in psychotherapy whatever direction it takes.

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COMPREHENSIVE TEXTBOOK OF PSYCHIATRY

Alfred M. Freedman and Harold I. Kaplan, Eds.
Baltimore: Williams & Wilkins. 1967. 1666 pp.
\$24.75

The aim of this textbook is to foster professional competence, and it must be said at the outset that the range and depth of information provided fulfills that aim. The book is one of the largest textbooks of psychiatry ever written. Few will read its pages from cover to cover. The content is divided into 11 "areas" covering certain fundamental aspects of psychiatry, impor-

tant clinical issues, and various related topics. A brilliant array of 174 contributors have been assembled. The quality of writing in all chapters is excellent. Scholarship and style are combined in a most pleasing and satisfying way.

Clearly the usefulness of the book must stand or fall on its capacity to serve as a source book and reference compendium. Short of writing an encyclopedia, this book comes nearer than most to being comprehensive. However, while it is systematic, thoughtful and thorough, it is not (nor can it be) completely comprehensive. For example, the problem of elective mutism in child psychotherapy is not discussed, and the method of use and drug dosage of Imipramine in the treatment of enuresis in childhood is not described. The chapter on drug addiction does not include any discussion of S.T.P. usage and the contraindication of Chlorpromazine in its withdrawal management is not noted. The original work of Papez is not mentioned in the detailed account of the limbic system, although a wealth of other details are included (e.g. "the post-commissural fornix of the rabbit starts out with 200,000 fibers, whereas the cat starts out with 100,000 fibers of which 100,000 reach the mammillary body"). Admittedly these are small points, perhaps even esoteric, but the psychiatrist who turns to this large book as a comprehensive source of these and other details is likely to feel frustrated when his expensive investment lets him down.

Perhaps what we are dealing with here is a reflection of a general problem that is besetting medical education in general and possibly psychiatry in particular. We have known for some time that a physician can no longer be an expert in all the specialties. However, it is now apparent that the specialist, and even in some cases the subspecialist, cannot know everything in his special field.

The editors have attempted to deal with this problem by multiple authorship. Insofar as general textbooks are still used, this is probably the best solution at the present time. Yet it must be obvious that such a huge area as child psychiatry, for example, cannot be covered in a comprehensive

manner within 186 pages, nor community and social psychiatry in 65 pages. Books on selected aspects within each of these areas alone are being published every month. The question instead becomes one of selectivity and presentation of a point of view within a specific scope. The scope and selection in this book are rational and reasonable, and represent a broad yet sufficiently detailed account of the significant areas in psychiatry in the United States. The novice may feel there is an *embarras de richesse* in this book, while at the same time the initiated inevitably finds that the account of his own special field falls short of his expectations. That must be the price of large textbooks nowadays.

Perhaps a more serious criticism lies in the point of view expressed by the editors. The editors have declared that eclecticism is the guiding motif in their book. Eclecticism, like democracy, is a beautiful idea but a difficult practice. No psychiatrist can be professionally competent without a theory, and the so-called eclectic is no exception. His very shifting from theory to theory is a theory in itself. This leaves the reader with the task of discerning the theoretical basis (or bias) of the individual author, and the reasons for his choice. For example, a statement is made (p. 1320) that "Aggression is no more fundamental or ubiquitous than is generosity." Agreed or disagreed? What is the evidence for this statement? Freud is dismissed, Lorenz and Storrs are ignored, and the reader can only accept or reject the statement; he cannot judge because the evidence is not marshalled. This is not good science. True, in the chapter on classical psychoanalysis the evolution of the instinct theory is traced to the point where formulation of an aggressive drive is required. But there is no cross reference to this discussion in the context of the earlier statement just quoted. Unless, therefore, the reader is energetic or otherwise informed, he is likely to be misled. And who can read the whole book when he wishes to inform himself only on one topic at any one time?

Herein lies the chief flaw of the book: it lacks the feeling of synthesis. Instead, the book is really a collection of excel-

lent papers, without a consistent point of view. Indeed, this appears to be the very aim of the editors, namely, to represent, and only represent, many different points of view. There is nothing wrong with presenting different points of view; but a critical commentary by such experienced psychiatrists as Freedman and Kaplan would have immeasurably enhanced the value of their contribution and would have created a truly outstanding textbook of psychiatry.

A book as large as this one must inevitably incur certain additional minor criticisms. Included among these are the problems of balance of subject matter, the repetition that occurs, the partial integration of knowledge from such related fields as ethology, anthropology and sociology, and the evanescent nature of editions that are out of date before they are published. Although this book suffers these minor problems, it comes closer to dealing with them successfully than any other equivalent modern book.

The problems of balance and repetition are especially vexing. The editors have clearly struggled earnestly with them. One of their solutions for the problem of balance is to set out common matters in large print and relegate certain details to small print. However, this stratagem is not always successful; sometimes important information is placed in small print, e.g. the toxic effects of such drugs as Dilantin and Tridione (p. 477). At other times less relevant information is included in the large print text, e.g. "intrauterine curare will lead to ankylosed joints in the sheep" (p. 1321) in the section on child development. Similarly, some repetition has occurred. For example, specific information on the views of Locke, Rousseau, and Darwin is given twice, once on page 1313 by one author and again on page 1321 by a different author.

But when all is said and done, *Comprehensive Textbook of Psychiatry* accomplishes more than any other major textbook in psychiatry today. The immense amount of work involved in the sheer organizational aspects alone commands admiration. Drs. Freedman and Kaplan are to be congratulated on their achieve-

ment, and the book can be recommended to psychiatrists who wish to enlarge their knowledge of their field.

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ON THE DEVELOPMENT OF MEMORY AND IDENTITY

Jean Piaget (translated by Eleanor Duckworth)
Barre, Mass.: Barre Publishing, 1968. 42 pp. \$3.75

This little book reports two talks delivered in 1967 by Piaget at Clark University as part of the university's annual Heinz Werner lecture series. Each talk very briefly summarizes recent Genevan research now or soon to be more fully reported elsewhere.* Both investigations have the attributes one has come to expect of Genevan research: highly original theory coupled with simple but extremely ingenious experimental methods; a resulting body of developmental data which will need careful validation, extension, and refinement by others.

The main point of the memory research is to demonstrate that what gets into the child's memory storage initially is importantly determined by the child's attained cognitive level with respect to the material to be remembered and—a more novel claim—that what is later retrieved from storage may be colored by any developmental changes in his cognitive level that have occurred during the interval (e.g. several months) between the initial presentation and the recall test. If a child is shown a series of sticks ordered by

* For the memory studies further details can be found in *Mémoire et intelligence* by Piaget, Inhelder, and Sinclair (Paris: Presses Universitaires de France, 1968) and in a forthcoming chapter by Inhelder, "Memory and Intelligence in the Child" (in *Studies in Cognitive Development*, D. Elkind and J. H. Flavell, eds., New York: Oxford University Press, 1969). The research on identity is soon to appear as a monograph in Piaget's *Etudes d'Epistémologie Génétique* series (also Presses Univ. France).

length, for example, what he will recall having seen when tested a week later will largely depend on his current grasp of seriation operations. A four-year-old (preoperational) child might for instance simply recall a dichotomous array: a group of "big" sticks plus a group of "little" sticks. When retested six months later, however, Piaget reports that the child's memory for the series (which he has not seen during the interval) may actually *improve* somewhat, apparently as a function of the added understanding of serial operations which these six months of cognitive growth have produced. Piaget views memory as a coding and decoding operation and hence entailing some code. This code, however, is dependent upon the child's cognitive-developmental status (his repertoire of intellectual schemas, operations, and the like) and hence changes with age. Assuming that Piaget's provocative results prove replicable, further research will surely be needed to clarify the precise contributions, to the child's recall, of developmental changes in the "memory trace" itself versus developmental changes in cognitive expectancies.

Piaget is perhaps best known for his research on children's acquisition of cognitive invariances. He has shown that the infant gradually comes to realize that objects keep their existence (their "object-hood") invariant in the face of transformations of position in space, e.g. when they have disappeared from his view; and he has shown that the 7-11-year-old gradually comes to realize that objects also keep various other, more quantifiable attributes invariant (numerosity, length, area, etc.) under certain physical transformations. The former acquisition is referred to as the object concept or object permanence and the latter ones as conservation concepts. What is the formal difference between the two? Piaget argues in this book that the object concept is an early acquired example of preoperational *qualitative* invariants, whereas the conservations are *quantitative* invariants which require concrete-operational structures as conceptual underpinnings. If water is poured from one glass into another of

different width, as in Piaget's conservation of liquid quantity task, the preoperational child is well aware that it is the "same water" (qualitative invariance, or "identity") but does not yet realize that it must also be the exact same *amount* of water (quantitative invariance, or true "conservation"). Recent research in Geneva and in this country (by Elkind, Murray, Bruner, and DeVries) has turned up a number of these qualitative invariants, thus adding a sense of developmental continuity to the wide age gap between the acquisition of object permanence and the mastery of the various conservations.

Despite his 72 years, Piaget's creative output shows not the slightest sign of abating. Were more of us like him, the field of child psychology would be making truly extraordinary advances. Were all of us like him, its companion field of gerontology would have no *raison d'être*.

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EARLY EXPERIENCE AND BEHAVIOR

Grant Newton and Seymour Levine

Springfield, Ill.: Charles C Thomas. 1968. 785 pp.

The continuously increasing quantity of scientific facts appearing at a continuously increasing rate are requiring that more attention be paid to synthetical presentations of large scientific materials. For the scientist in the midst of his work in a special field, it has long been impossible to read the literature even in areas close to his own work; for the practitioner in any field it is completely impossible to follow the scientific progress by reading the special articles in all the journals dealing with subjects included in his daily work.

The interest in the sphere of ontogenetic development has been steadily increasing over the past few years. New research areas have been opened up, but also in many of the old areas new techniques and new ideas emerging out of the

general progress in the life sciences have been incorporated. Quite naturally these new routes of research are of great interest for the clinician dealing with different aspects of orthopsychiatry. Grant Newton's and Seymour Levine's editorial efforts in shaping the volume *Early Experience and Behavior* deserve appreciation as a very important contribution to the synthetic literature which is so badly needed nowadays in the field of ontogenetic development.

The book is a very comprehensive survey of the comparative psychobiology of development. The importance of it depends not so much on its detailing of various research approaches but on its attempts to synthesize the role of epigenetic factors influencing development. Some might object that the editors have tried to incorporate too much material. My opinion, on the contrary, is that they have not gone far enough. Divergencies of opinion in this respect only underline the difficulties involved in the decisions that the editors have had to make.

The volume spans vast material. Eighteen chapters by 26 authors cover subjects ranging from the epigenetic interpretation of imprinting to the role of critical periods in development, from the influence of hormones, brain chemistry, anatomy, and homeostatic mechanisms involved to the search for the engram in the nursery. While recognizing the methodological difficulties involved, the authors try to evaluate the role of various stimuli and their effects on the psychobiology of development. The book ends with a chapter attempting to survey the factors and developmental traits common to mammals from rat to man. The effects of maternal deprivation and its critical periods during infancy are discussed in the light of various research results from a study of groups of children reared in institutions.

In evaluating the actual content of the book I cannot avoid observing that, although it contains vast material, its scope could have been even broader. In the chapter about the imprinting phenomenon, for example, one cannot find a single word about one of the greatest discoveries in sensory physiology of today, namely the

observation of Hubel and Wiesel about the optimal response of cortical visual neurons being determined by the position, the form, and the movement of a visual stimulus. In the chapter "Hormones in Infancy" by Levine and Mullins, on the other hand, there are several references to recent works about the actual anatomical and physiological effects of various hormones on brain neurons. Likewise the chapter by Shapiro, "Maturation of the Neuroendocrine Response to Stress in the Rat," contains an overwhelming amount of literature pertinent to the subject. Shapiro's statement that "the effects of early experience on the maturation of the central nervous system and behavior, brain biochemistry, stress resistance, and homeostatic efficiency in the adult should prove to be an especially rewarding area for future investigations" points up my criticism that the scope of this volume should have been wider, since ultimately the phenomena studied in behavior will have their full explanation on the single cell level and the molecular plane. The last chapter of the book, "Early Deprivation in Mammals: A Cross Analysis" by Bronfenbrenner, is an excellent overview of the field treated in the book but one can't help missing the references to works on the molecular plane. I understand, though, that such a chapter could hardly be written by one man and that such an enormous amount of material could less likely be included in one chapter. The book is thus an example of the positive outcome of interscience communication which at the same time illustrates the difficulties in meeting all the requirements.

In the limited space at hand it is of course impossible for me either to deal with any one subject at any length or to deal with all of them. I can state, however, that the book serves as an introduction to the research field of the psychobiology of development as well as a source of information for the specialist in the field. Although the molecular biologist might ask for more information, the practitioner might find some parts of the book rather advanced. In all cases, though, one is struck by the great clarity in the presentation of the various topics, which adds to

the reading pleasure for both the specialist and for his colleagues in related theoretical and practical fields.

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DISEASE, PAIN & SACRIFICE

David Bakan

Chicago: University of Chicago Press. 1968. 144 pp. \$5.95

PAIN: PSYCHOLOGICAL AND PSYCHIATRIC ASPECTS

H. Merskey and F. G. Spear

London: Baillière, Tindall & Cassell. 1967. 223 pp. \$8.50

Those who are concerned about the dehumanization of psychology by the cultists of "scientism" regard David Bakan as one of their leading advocates. The role suits him well, for his scholarly efforts are refreshingly original while firmly rooted in science, history, and philosophy. The present volume is consistent with previous work, and its intellectual virtuosity makes it a rewarding experience in reading. One may disagree with Professor Bakan's theorizing, but even so one is richer for having read him.

The title given these three brief essays might have been "The Concept of Telic Decentralization," but had it been so named wide readership might have been discouraged. Yet it is this concept which binds the three essays. It is an interesting concept which rests upon a rather creative synthesis of Freud's notions of defense and of "death-instinct" and the equally controversial view of Hans Selye on adaptation. An important building block in Bakan's theory is that "defense is a key notion for unlocking at least some of the mystery of the disease process." He speculates further that the mechanisms Selye identifies as "adaptive" are similar to those identified by Freud as "defensive." The logical development from this, then, is that the organism is *adaptively injured* physically in the same way as it may be

defensively injured psychologically, as in neurosis. This is intriguing speculation, and it is fascinating to trace with Bakan the convergence of Selye's observations and those of Freud regarding the death-instinct. In effect, what the author has done is to present theoretical constructs to explain those mechanisms in man which bring about his own disease and death.

Bakan is profoundly committed to the relevance of empirical data. It is here that issue may well be taken. Unfortunately, Professor Bakan turns to the literature on the psychogenesis of cancer—and he does so with little critical discrimination. But, then, if one considers his extreme sensitivity to the destructive constraints of "scientific method" as described in his *On Method*, his inclusion of all kinds of empiric data is understandably consistent.

The most unfortunate aspect of this book is its brevity. Bakan has crammed so much into these three short essays (the longest, 46 pages) that it is difficult for him to satisfactorily develop his highly complex theory. It is to be hoped that the present volume is prologue.

The book by Merskey and Spear is essentially a "review of significant papers which deal with pain from a variety of psychiatric and psychological journals." In addition, the authors have collected data from physiological, general medical, and several nontechnical sources and, after considering a number of theories (particularly those of Szasz), they offer a "unitary view of pain."

The authors are to be complimented on a monumental research effort and on having achieved early publication as well. There are 31 pages of bibliography for 176 pages of text, with references to publications as recent as 1966. For a brief but relatively exhaustive overview of the subject, this book will serve admirably.

There are, however, some glaring deficits. For example, there are only two indexed references to placebos and only two to suggestion. In view of the growing literature on the placebo effect, both experimentally and clinically, particularly as regards pain therapy and the entire field of psychopharmacology, this is surprisingly short shrift.

But to indict this brief overview on such grounds would be to compromise the contribution by the authors. They have made a noteworthy contribution in a complex area; what is more, they achieve their goals with distinction. In this age of the "publication flood," we must be grateful for any effort to ease the burden of "keeping up"—this book does it well.

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THE CHILD AND THE REPUBLIC

Bernard Wishy

Philadelphia: University of Pennsylvania Press.
1968. 205 pp. \$6.95

According to Bernard Wishy, Americans gave up their Calvinistic belief in the natural depravity of children between 1830 and 1860. By the time of the Civil War most parents and teachers had come to accept the notion that children were redeemable through proper nurture.

Parents learned about the new style of childrearing from new periodicals like *Mothers' Assistant* and *Parents' Magazine* and from newly formed maternal associations. Teachers received the message through new education journals like *The Common School Assistant*, the *American Institute of Education*, and the *American Journal of Education* and from newly created teachers institutes and normal schools. From these sources of information parents and teachers learned that to ensure proper nurture, one must follow nature. Thus infants should be breast fed—nursing followed nature's pattern—and older children should receive a simple diet—natural foods like milk, clean, cold water, wheat bread, and vegetables—rather than distorting diets of cake, fruit, pastry, confectionary, coffee, tea, liquors, gravy spices, preserves, or meat. Moreover, bodily freedom was natural, so swaddling and overdressing (caps, hats, bonnets, cravats, pelisses, frills, ruffles, gloves, ribbands, and "other paraphernalia") were

forbidden. Exercise and fresh air were a must. It was natural for children to romp and run, to be spontaneous and joyous. Of course, there were unnatural tendencies that had to be punished. But punishment, too, now became enlightened: punishment had to fit the crime. Parents learned to spare the rod and save the child. More important than punishment were the positive inducements of expressions of love and affection toward the child. The experts recommended kisses, hugs, and frequent embraces, combining this with appeals to conscience and reason.

What Bernard Wishy found most significant about the pre-Civil War period of child nurture was the attempt made to reconcile a new freedom with traditional morality. "Though the methods of child-rearing were to be more loving and tender, the character desired for the child was not significantly different from long-established conceptions of the ideal American, Christian, citizen." He shows how this ideal of traditional, abstract morality was reflected in the children's stories of the time and in the reading books, the spellers, the history textbooks published during this period.

After 1870, Darwinism provided scientific ground for child nurture. Now the truths of biological evolution reinforced the already accepted notions of the gradual development of the child's powers and sparked innumerable scientific investigations of the development. The avalanche of monographs and books describing these studies led, in the 1880's, to the founding of child study clubs and new journals of child study.

One of the consequences of this new deference to scientific knowledge was that childrearing and education itself became a serious scientific experiment. The "new education" was originally created as a means to preserve traditional ideals in an industrialized, urbanized world. John Dewey, the most famous leader of this "new education," urged teachers and parents to identify the real needs and instincts of childhood, which, if fulfilled and allowed to develop, were to lead to the discipline and culture of adult life. For Dewey and other advocates of the "new

education," the "process" now became the valuable part. Not the answers, not facts, not set lessons, but the process of learning, growing, developing (for Dewey they were all the same).

The message of Mr. Wishy's book seems to be that child nurture, appearing originally as a means to inculcate the old traditional values and ideals, became, at the turn of the nineteenth century, an end in itself. This coincided with and was in keeping with what Wishy calls the rising tide of moral and social pluralism in American society. Not all Americans were happy with this. Against this tide of pluralism, he situates a number of moralists—Mark Twain, Henry James, Frank Stockton—who wrote about children who were loyal to high (absolute) ideals and served as a rebuke to corrupt adults. The use of this theme as a label for the second half of the book, "The Child Redeemer," confused me a bit since only the novelists—not the educators or psychologists—so regarded the child.

In his preface, Wishy says he believes his book is a needed contribution to the iconography of the American child. It is. Unfortunately, what he gives us is one more book by an historian, for other historians. This is too bad, since Wishy at times writes lucidly and with verve. Had he placed his material in a broader social-cultural context and written more about the problems these early practitioners of child nurture were trying to solve, he could have broken the subject matter barrier. As it stands, *The Child and the Republic* will now become an additional source to be checked and cited by historians who by and large will continue to write for other historians.

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INTELLECTUALS TODAY

T. R. Fyvel

New York: Schocken Books, 1968. 240 pp. \$6.95

A title like *Intellectuals Today* conjures images of revelatory creative and scien-

tific brilliance and energy, as if one were being invited to a fresh rediscovery of the life of the mind—but then the subtitle, *Problems in a Changing Society*, brings us back with a crashing drag into what Fyvel is pleased to call "the intellectual climate of our times." According to his meteorology, that climate is to be defined mainly as a convergence of all the cloudy issues hovering in the pages of our weeklies and monthlies: the bomb, the pill, the media, violence, the generation gap, race conflict, the fission of ideology and religion, and so forth. His opening premise is that "not constancy but only change has come to seem normal," and he offers to give us some bearings amidst all this druggy confusion and flux of our time by exhibiting the thoughts and language of the hosts of young intellectuals he interviewed in England, France, and Germany in 1965 and 1966.

All are in their twenties or early thirties. Thirteen are identified by name and given four or five pages each. Several dozen others, given a few sentences or paragraphs and subjected to heavy editing, are introduced by speech prefixes like YOUNG PHYSICIST, FRANKFURT; ECONOMIST, COLOGNE; (FORMERLY) LEFT-WING JOURNALIST, PARIS; DRAMA EDITOR, LONDON; PUBLISHER'S EDITOR, HAMBURG; EX-COMMUNIST FILM WRITER, PARIS; LEFT-WINGER (YOUNG WOMAN); TEACHER OF LINGUISTICS; BRITISH PUBLICIST; MATHEMATICAL BIOLOGIST; PAINTER AND ART CRITIC; CONSERVATIVE INTELLECTUAL. Most of them seem to have been expensively educated (either at public or private expense) and those who are not already well-known are at least upward bound in their respective academic or cultural establishments.

Fyvel is much too generous with their most casually formulated opinions, many of which on inspection express little more than a vague apprehensiveness about the future:

The major problems for all Western countries alike are becoming technical. They are how to run a fully-employed economy, how to stop inflation, to provide maximum social welfare where needed, how to deal with urban transport, how to improve education. . . . [p. 158]

Frankly, I'm less worried by any thought of

doomsday than of being computerized. Control over the individual in the next twenty years is bound to be very much speeded up. . . . [p. 173]

It's a mistaken belief that an affluent open-market society must be free. Politically it can be most illiberal and unbearable. Sociological enquiry can here itself be a liberating force. Television is perhaps another new factor for national insight. . . . [p. 147]

At thirty I feel that my generation which has occupied new positions of power is still in between. It's the generation following us which is the different one. . . . They give the impression of a rising movement of anarchist philosophy in poetry and painting and politics. . . . [pp. 212-13]

Their views, at least in the homogenized collection of snippets that Fyvel provides, appear to be virtually interchangeable; but of course the contributors generally read the same kinds of journals and respond in roughly similar ways to the same political and social cues. A roving reporter on a cheap tabloid gets more idiosyncratic and stimulating responses from the man in the street. The book as a whole, although it includes a few engaging personal reminiscences, is an anesthetic bore.

Three sections make up the book: "Setting the Scene" sketches the history of the English intelligentsia from the 1920's (alienation, exile, or isolation from philistine society) to the 60's (integration into an affluent consumption-oriented economy); no surprises here. "Conversation Pieces" presents the longer interviews, gathered (not organized) under such chapter-headings as "Talking of Science and Art." The final part, "Recurring Themes," mingles shorter quotations and authorial comment under such headings as "National, International." There is no more of a consecutive argument than one might expect in a 24-hour TV panel show.

There are, on the other hand, some continuities of attitude that provide the book with a certain coherence, both in Fyvel's selection of guest lecturers and in scattered comments of his own:

PHILIP WINDSOR: I took history at Oxford, but was always interested in history of ideas in the Germanic sense, which is not easy to

study in England, where they prefer you to write a monograph on more restricted research. In my year at Berlin, though, I had the good fortune to be taught by Professor Herzfeld, one of the historians of the Old Guard who would spend hours and hours talking about ideas and kicking them around among the students.

I had the luck to be at St. Anthony's College during the first flowering of European feelings . . . in the late fifties. . . . [pp. 120-21]

Home base for the book is the academic common room, and the undeveloped "ideas" that Fyvel himself puts forward are imposed largely by the echoes of his tone from the oak panelling:

[Of France:] The fact that for the first time since 1789 the country has no rebels, no real movement of socially and politically angry young men, has since de Gaulle's advent in 1958 become so evident that it hardly occasions comment. [p. 211]

[Of Russia:] Today who remembers the peasant Krushchev and his place in the slow Soviet progression from Stalin to normality? [p. 172]

Written before the student riots and the Czech invasion, the book improves in sociological value as it very rapidly dates. And although Fyvel generally professes egalitarian social convictions, his aesthetic judgments show a fuzzy wistfulness about the breakdown of all the fine old distinctions that calls into sharp question his capacity to report fairly the current intellectual scene:

I would also agree with Mr. Lucie-Smith that in much Pop art, the work "is merely the raw material; the finished result is the theory which the critic makes up about it." I had this feeling about much of the American intellectual reaction to the Beatles. As compared with the English appreciative-ironical view, much American critical comment . . . had that uncomfortable, wrong note of seeking significance where there was none. [pp. 216-17]

The "appreciative-ironical" tradition allows for no uncertainty about where significance is to be found and is as keen to detect "that uncomfortable, wrong note" as to single out Krushchev's peasant orig-

ins and manners. As an antidote to Fyvel's book, I recommend Hunter Davies' recent biography of the Beatles—e.g. John Lennon's anecdote about meeting Elizabeth:

We collapsed, the whole thing was so funny. There was this Guardsman telling us how to march, how many steps, and how to curtsy. . . . I really think the Queen believes in it all. . . . I don't believe in John Lennon, Beatle, being any different from anyone else, because I know he's not. . . . But I'm sure the Queen must think she's different.

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TOWARD A SOCIETY OF LEISURE

Joffre Dumazedier (translated by Stewart E. McClure)

New York: Free Press, 1967. 307 pp. \$6.95

This is a very topical book on an issue which today has assumed increasing importance. One hundred years ago, factory workers the world over worked from dawn to dusk, ate their dinner and went to bed. Today, people think very little of traveling from New York to California for the weekend in such large numbers that airline delays over New York City on the way back cause the stacking of planes as far west as Denver. Equally striking is the fact that flying personnel aboard those planes work, by regulation, less than 20 hours a week. Safety considerations, you say? Then note that union electricians in the City of New York now have a legal work week of 20 hours. "Dawn to dusk" is an archaic consideration these days, and the more annoying aspects of leisure-time activities—the crowding of airways, highways, golf courses, and beaches—move into the forefront of public consciousness.

Readers of this JOURNAL will recall Freud's comments about the role of work in the life of human individuals. The psychoanalytic system stressed the importance of satisfying work in the healthy personality while implying that those who sought pleasure alone were behaving in a

neurotic fashion. With an eye to both these base lines, Professor Dumazedier has surveyed what the French workers do with their leisure time. As David Reisman points out in his scholarly introduction, Dumazedier's approach involves a "moralism more characteristic of Soviet than American scholarship." This is, I suspect, another way of saying that there is a certain grim quality to Dumazedier's preoccupation with leisure. This character is seen early in the book in his opening statement that "a theoretical system that neglects to take full account of leisure risks being maimed from inception." Out of this orientation, the author comes to the view that leisure is central in society and that much more planning is necessary with regard to free-time activities. Dumazedier is for: (1) a closer coordination between school reading and adult scholarship; (2) a better distribution of vacation time; and (3) alleviation of the housewife's "porous" work day. Similarly, he is against: (1) facilities which revolve around out-of-country tourists; (2) leisure planning which neglects those who live in rural areas; and (3) laissez-faire government policies toward leisure time.

The book is certainly scholarly enough, and anyone reading it will know a great deal about the sociological approach to the matter of leisure-time activities. Perhaps the caveat comes in the statement "certainly scholarly enough," for it does have a heavy quality which stands in stark contrast to its central thesis. There is not a humorous allusion in three hundred pages, and this stands in stark contrast to certain unscientific (I suspect) assumptions regarding Gallic humor. I can't help but feel that leisure and enjoyment should stand in close correspondence with each other but this idea is not borne out by the style of Dumazedier's book.

Finally, the translation is execrable. As an example, let me submit the following paragraph:

In the United States and in Europe—here in France—various global-historical investigations are under way or projected. Until their results are in, we reserve decision—stay this side of what we know for certain, and meanwhile take as guide an inflexible principle:

Before embarking on research or theory or action of any kind, pose the problem in terms indisputably inherent in the advanced social and cultural context of our own day. It will be no small gain if we succeed in throwing light on whatever fundamental changes have taken place in the phenomenon of leisure since the time when those well-known major ideologies were elaborated which our present society, barring some few isolated attempts, has still scarcely bothered to reconsider, or lay open to question. The chips are not down.

Although Professor Dumazedier is a sociologist and sociologists perhaps write even more obscurely than psychiatrists and psychologists, it is hard for me to believe that the problem lies with professional language. Even if this were true, a translator has the responsibility for cleaning up fractured prose.

To sum up, this is an interesting and valuable book for professionals on a new field of social concern. It is not for summer reading and its style is marred by poor translation.

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... AND A TIME TO DANCE

Norma Canner and Harriet Klebanoff
Boston: Beacon Press. 1968. \$5.95

... and a time to dance is a beautiful little book about movement and what movement can do for even severely retarded children. It tells the story through enchanting photographs which provide glimpses of the children's joyous faces and bodies as they respond to the inspiration of music.

The joy is important in itself, as part of the enrichment of experience of small children who formerly were regarded as "vegetables" and even left to deteriorate in sodden, institutional neglect. It is also important as a reinforcing aspect of a total program of enhanced development and living. Intrinsic satisfaction and pleasure is a basic reward for learning and achievement—children want more and more of

whatever is fun. And when retarded children dance joyously in their nursery school, some of the glow must rub off on the place, the teachers, and the group—to make school a desirable place and going to school a welcome part of life.

But the joy of movement, emphasized here, is only part of the contribution of dance, and more study could well be given to the various developmental effects. Movement activates the mind as well as the body. It not only contributes to better bodily functioning but to more alert awareness, more response to the environment, and even, as recent work with the brain-damaged has shown, to improved use of brain cells and nervous system.

... and a time to dance does not deal in technicalities or research potentialities. But I hope it will be both an inspiration to those who are developing programs for young retarded and brain-damaged children and a catalyst which stimulates new efforts to discover potentialities in these children and how to release them. For people with many different backgrounds concerned with young retarded children—their own families included—this book will be a wonderful revelation.

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STUDIES IN PSYCHIATRIC ART

R. W. Pickford
Springfield, Ill.: Charles C Thomas. 1967.

This book is a collection of the papers of R. W. Pickford, professor of psychology at the University of Glasgow—all previously published during the past 30 years in various British and Scottish psychiatric journals. Most of the papers deal with aspects of the art productions of psychotic or deeply disturbed patients, both adults and children, but Pickford also includes reports on the lives and work of some well-known artists who suffered severe emotional disturbances which were expressed in their paintings.

Professor Pickford explains in the Pref-

ace to this book that his interest in the subject of psychotic art productions by mental patients and emotionally disturbed artists was first stimulated by hearing the late British psychoanalyst W. Ronald D. Fairbairn analyze and interpret the paintings of disturbed artists from the Freudian viewpoint. This led Pickford into an investigation of the psychodynamic approach to art of disturbed patients in Freudian terms.

Frequently Pickford's discussion of the cases of patients whose pictures are included seems too theoretical and academic. He shows no awareness of the value of encouraging patients to offer their own "free associations" to the spontaneous pictures they create. At the end of the first chapter he summarizes his conception of the values of art from the point of view of psychotherapy as follows: "The use of art by a patient in order to communicate his problems and conflicts to himself; that the art productions of patients and non-patients express and utilize in sublimated ways their unconscious aggression and sexuality. By the therapist's analysis and interpretation of artistic works by patients he can promote the development of insight and readjustment to the patient's life."

Pickford has here emphasized the importance of the therapist's analysis of the patients' art productions and this is the role that he has himself played in the writing of this book. As a psychologist he has discussed the application of the Freudian approach to psychotic art but as a psychotherapist has made no attempt to treat cases of disturbed patients with the inclusion of their spontaneous art productions. This means that the greatest value of the book is to introduce to those as yet unacquainted with the value of the art therapy approach, its significance in the treatment of disturbed individuals.

Two of the most interesting chapters are concerned with the art productions of disturbed children. One is the report of a case study by Melanie Klein, "Some Clinical and Artistic Aspects of a Child's Drawings," and another is on "Paintings by Delinquent Boys." Both of these papers should make art educators as well as psychiatrists and psychoanalysts more aware

of the value of the spontaneous art productions of patients in psychotherapy.

The book also includes a report on an exhibition in 1955 of the art of psychotic patients as shown at the Institute of Contemporary Arts in London. The many exhibits of the art of psychotic patients in Europe was originally stimulated by the publication of Han Prinzhorn's book *Bildnerei der Geisteskranken*, published in 1922. This was the first book to rouse interest in the art of schizophrenic patients. Today, there are permanent collections of the art of psychotic patients in such psychiatric institutions as St. Anne's Hospital in Paris and Maudsley and Netherne Hospitals in England. But too little has as yet been done by Pickford or others to relate such spontaneous art productions to the therapeutic treatment of patients.

Pickford, while admitting his identification with the Freudian approach, does include a case study of a patient treated by the Jungian approach, which illustrates with the aid of pictures how a Jungian use of a patient's symbolic art productions differs from the Freudian approach.

The final chapter, "Some Problems in Classical and Modern Art," attempts a review of the emotional crises in the life of artists such as Goya, Van Gogh, and others. But this material is dated and has been superseded by later psychological and psychiatric studies of artists.

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HOW MANY MILES TO BABYLON?

Paula Fox

New York: David White Co. 1967. 117 pp. \$3.95

Recently there has been a plethora of writing about the "disadvantaged child." Professional people who have worked with such children over the years, while welcoming such material, have found that a good deal of it was all too familiar even though sometimes couched in new language. Fortunately, along with the increase of professional, technical literature, there has also been considerable increase in

Negro autobiographies and novels written for adults. Now children's literature is also beginning to recognize that it is safe and appropriate to present to the young reader a picture of the Negro American child.

Most attempts in children's literature have so far been all too bland, exuding a liberal, tolerant air that implies everybody is like everybody else except maybe their skins are a somewhat different color. The illustrations in such books make the fact of color obvious, and yet there may be no word at all in the text suggesting it is present. Poverty may be vaguely suggested, or may be dealt with in some of its less ugly aspects. Most striking is that these juveniles almost invariably present an intact family picture, with the father working and mother at home. Perhaps such books may help overcome some of the fears of the too insulated suburban or well-to-do city child (who after all is the child who sees current children's books) as an antidote to the view of the Negro received from TV and other popular media accounts of situations such as Watts. Also Negro children (again the middle-class ones for whom books are available) can develop more sense of self by seeing their own lives in books.

But only recently have a few books appeared, geared for children but intense and real enough to be of great meaning for adults too, which depict the life of the Negro child in the slums with some of the harsh realities. White parents and librarians may fear to expose children to such painful material and feel this may intensify prejudice and sense of distance. Negro middle-class parents, unless ultra-militants, may also be reluctant to let their children see such books, fearing they will have a downgrading impact. But perhaps children are tougher than we give them credit for being; and they do relish sad, even tragic stories. The white middle-class children to whom I have given *How Many Miles to Babylon*, have read it with the same enthusiasm as they have a half dozen of the blander books.

Paula Fox has broken new ground in particularizing the slum child into an individual—James—and has dealt with some of the most essential aspects of the life of

many such children. It is a book which children and adults, professional and non-professional, will relish. A combination of great sensitivity and lyric tenderness, it shakes loose from all the clichés and sees the world of slum children through their own eyes.

James is living in a half world, pained by many things around him and unable to make sense of others. He tends to find school highly irrelevant, although he is enough concerned and worried about the teacher's attitude that he makes a few sporadic attempts to listen. Some of the most vivid parts of the book—which had best be read by Head Start people—are of the dreamy moments in school and the very graphic descriptions of the other children.

Occasionally some kind of window opens for James. He turns to his fantasy of his mother as a queen in Africa and, as one of my young readers commented, he "thinks he was a prince when he was nothing." The great window opens again during some cliff-hanging episodes with older boys. These are fraught with terror, but in his wanderings with these boys James comes to Coney Island and for the first time sees the Atlantic Ocean.

The first part of the book may be considered most valuable by many clinicians because of its picture of daily life with its monotony, the adults working, the child dreaming in school and wandering through the streets at loose ends. However, the adventure takes over for the bulk of the book. Some adult readers may dismiss this part as being mere romance, but adventures do happen with a fair amount of frequency to unprotected, neglected children such as James and the three older delinquents who "capture" him and use him for a pawn in their crooked schemes. It is while in bondage to these boys that he gradually develops a sense of himself. James is no helpless Poor Little Match Boy, but a boy of courage and ingenuity, and it was this that most impressed one of my nine-year-old readers.

As part of the total honesty of the book there is not a usual "happy ending." James manages to some degree to escape from

his oppressors, and his mother returns, but he is still there in the slums.

He looked at Aunt Paul's bed. The bed hadn't been slept in. He looked at the linoleum floor, at the hole in the ceiling, at the coffee pot. Then he looked at his bed.

A small woman was sitting on it. Her hair was cut close to her head so that it looked like one of the thistledowns Miss Meadowsweet had brought to school for nature study. She had on a dark dress and she was wearing slippers. She was hardly any bigger than Gino. James stood still. But where was her long white robe? Her long black hair? Where were her servants and her crown?

Aunt Paul pushed him forward. He took a step. Why, she was hardly bigger than he was! How *could* she be his mother?

He was tired. He wanted to lie down somewhere, anywhere. He couldn't move. Then James felt happy.

As though she had read his mind and heard his question, his mother held out her hand. "Hello Jimmy," she said.

The ambiguity of what has happened to the mother (whether she had been hospitalized for an agitated depression, for drugs, or for physical illness) is never resolved. What will happen now that she is home is also left ambiguous but James is there with her.

This book will be "strong medicine" for every reader, including the professional person who may be familiar with such children as cases. But James is a person not a case. Strong medicine or not, we need such books.

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GROUP COUNSELING AND PSYCHOTHERAPY WITH ADOLESCENTS

Beryce W. MacLennan and Naomi Felsenfeld

New York: Columbia University Press, 1968. 198 pp. \$6.00

A couple of decades ago, a series of experiments were conducted to test the

propositions that: (1) it is more feasible to alter the behavior of individuals in a group than to alter their behavior individually; (2) behavioral change effected through groups is more permanent than if individual behavior is altered singly; and (3) change is more readily accepted if there is group participation in the decision to change.⁴ The successful outcome of these and other studies since has stimulated considerable research in and practice with group techniques. Now we are in an era of social turmoil, concerned with the unemployed, the underemployed, the educational dropout. Group phenomena are involved significantly in these concerns—so too is youth. The advantage, then, of applying group techniques to the adolescent would appear to offer much promise.

The adolescent presents some of the greatest difficulties in psychotherapy. He is searching for his identity as a person, his role in society, and a means of expressing himself adequately. If he is from a socially disadvantaged background, all these problems are compounded and accentuated by inept communication skills. In individual therapeutic or counseling situations, the adolescent is often unable or unwilling to communicate with someone from another generation and probably with a different value system. With a group of peers, however, who speak the same language and quest the same dreams, the prospects of participation are brighter.

Nevertheless, the adolescent group situation is quite delicate. No one is more susceptible than is the adolescent to peer pressure. Group contagion is a serious factor which has to be contended with, especially when it is interlaced with strong impulse conflicts from which adolescents suffer so acutely. The group therapist not only must be versed in individual dynamics, skilled in group process, and knowledgeable about adolescence but he must be able to resist the temptation of being cast simultaneously in the role of the symbol of adult society. The group therapist must avoid the unreal, if sincere, effort to identify with the group members and must especially strive for authenticity. For teenagers are above all sensitive to

phoniness and stuffiness, particularly when they can support each other as in a group.

It was with dismay, therefore, that I read the following quotation in the introduction to this book: "In our chapter on the group leader and his training, we have stressed the importance of the leader's management of himself and our conviction that, provided he is a sensitive person capable of self-understanding, perceptiveness for others, *a leader does not require education for many types of group management but can be trained relatively quickly to counsel effectively* [italics mine]."

The authors well might have been describing the qualities necessary for a YMCA director (which is the source of much of the experience of one of the authors) or for a Boy Scout leader. They certainly are desirable traits for a group leader as well, but it is naive to deemphasize the necessity of thorough training for group counseling and psychotherapy with adolescents—which after all is the title of the book.

Unfortunately, the quote above sets the keynote for the entire book. The authors present platitudes and generalities from secondary sources concerned with groups and adolescents. This is sad because there is a dearth of relevant material in this field. The professional mental health specialist will gain little from this book with respect to either his knowledge about group techniques (he might read here with more advantage Mullen & Rosenbaum⁵) or adolescent behavior (the now standard work of Erikson³ is still to be recommended).

What can be found in the book are generalized accounts (reasonably well documented) of such issues as "Process and Maneuvers in Adolescent Groups," "Major Themes in Adolescent Groups," and "Groups in Different Setting." The other chapters deal even more superficially with "The Group as an Agent of Change," "The Adolescent and His Culture," "General Considerations in Group Counseling and

Group Psychotherapy," and "The Group Leader and His Training."

If the reader wishes a more sophisticated presentation, related meaningfully with pertinent research and with many excellent illustrations of actual problems taken up in groups, then he is recommended to *Classroom Group Behavior*.¹ Examples of how group techniques may be utilized in the schools can be found in a chapter in *School Psychology*.²

This reviewer concurs enthusiastically with the authors of the present book when at the outset they state "... in order to help the individual work out his problems there must be an understanding of the larger society and its pressures on his particular society. It is made clear that personal problems are often magnified because of dysfunction in the system and a general refusal to recognize it." But the promise of a unique contribution (which would be made if this point were further explored) is never realized and the dysfunctions of the system are never analyzed. The potency of adolescent critique and its constructive nurturance in groups—crucial to the application of group counseling and psychotherapy to adolescents—is not considered further.

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MENTAL HEALTH HIGHLIGHTS

by Jack Wiener

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Forecast of 1969 Legislation

? ? ? ? ? But Congressional action will be needed on major health laws which expire in 1970 and require legislative extension. These include the COMMUNITY MENTAL HEALTH CENTERS ACT, MENTAL RETARDATION CENTERS ACT, and the PARTNERSHIP FOR HEALTH ACT. Once again, appropriations will be crucial and uncertain.

Living Sick

A survey of what people think about their own health and about medical care brought out many disturbing findings. The study, conducted by the Louis Harris polling organization for the Blue Cross Association, involved a national probability sample of 1,057 adults in households across the U. S. To find out in greater depth about the health problems of the poor, additional subsamples were included of: (1) blacks in urban ghettos; (2) Appalachian whites in rural areas; (3) Spanish-speaking people in poverty clusters. Some of the survey results:

FOR THE GENERAL PUBLIC

- 60% of the people in the country sometimes feel "worried and nervous"; 52% sometimes feel "lonely and depressed"; 23% sometimes feel "emotionally disturbed."
- But half or more of the respondents would *not* talk to a physician about these emotional problems. For ex-

ample, 68% would not talk to a physician about being lonely and depressed.

- About half the public believe that there is a shortage of medical doctors.
- Although 92% think that "most doctors can be trusted," about $\frac{2}{3}$ believe that "most doctors don't want you to bother them."
- When asked what might be most helpful in "making their family healthier than now," 71% said, "Reduce the cost of medical care."

FOR THE POOR

- Nearly $\frac{2}{3}$ of city blacks and Appalachian whites reported that "feeling sick" was their usual condition.
- More than half the blacks and Appalachian whites said that their health is worse than their parents or grandparents.
- Compared with 11% of the general population, about one-fourth of the poor reported that someone in their family was seriously ill at the time of the interview.
- About $\frac{2}{3}$ of the poor are worried about getting money to pay for a doctor or for medication.
- Blacks frequently complain about the long waits for service at clinics and that clinic doctors "are not available when you need them."
- Half of the poor believe that doctors are too interested in making money.
- Three-fourths of the poor say it is not true that "the poor people get the best

medical care because they have so many free facilities available to them."

- The Spanish-speaking poor—mostly of Mexican or Puerto Rican descent—had different attitudes than the urban blacks and Appalachian whites. By and large, the Spanish-speaking poor were less worried about being sick and about getting adequate medical care.

LOUIS HARRIS. *Living Sick. Sources 1968:21-36, issued by the Blue Cross Assn., 840 No. Lake Shore Drive, Chicago, Ill.*

Low Birth Weight Increases Risks

Most children with low birth weights are not impaired and are similar to children with normal birth weights. But a Johns Hopkins' study found that, as a group, children with low birth weights (prematures) have lower average intelligence scores than those with normal weights. The difference between the two groups is not large—4.9 IQ points at age 8–10 years on the Wechsler Intelligence Test for Children—but it is statistically significant and large enough to be of public health concern.

Further, there was increasing intellectual impairment with decreasing birth weight. For example, 12.5% of the white children with very low birth weight had IQ's of 50–79 as compared with 4.8% of white children with normal birth weights. Similar impairments with very low birth weights were found for Negro children and for the different social classes.

Nineteen children were excluded from the study because of severe sensory or gross motor disturbances, or because of an IQ of less than 50. Of these 19 children, 16 had low birth weights and 3 had normal birth weights. The study discredits the common belief that prematures eventually "catch up" as they grow older. The investigators believe that the risk of impaired mental performance is greatest when low birth weight is associated with indications of neurological damage.

These findings come from a large, longitudinal study in Baltimore. An original group of 500 low birth weight babies

(2500 grams or less, or 5½ lbs. or less) and 492 full-term, normal weight babies were matched for such factors as race, socioeconomic status, mother's previous births, etc. The children have been tested every few years. In this portion of the study, 822 of the children who had reached 8–10 years of age were seen by social workers and psychologists who gave the Bender Gestalt test and achievement tests, as well as the Wechsler test. The investigators caution that the evidence from this study cannot be used to make a clinical prediction for a specific child.

In the Senate hearings before the Select Committee on Nutrition and Human Needs, it was pointed out that the premature birth rate is two to three times higher among the poor than among the well-to-do.

G. WIENER, R. V. RIDER, W. C. OPPEL, AND P. A. HARPER. *Pediatric Research, 2:110-118, 1968.*

Alone You Are More Human

Remember what happened to Kitty Genovese? She was attacked by a man at 3 a.m. on a street near her home. She screamed and called for help during the half hour that it took to murder her. Thirty-eight of her neighbors in Kew Gardens, New York came to their windows, but none went to help her or even called the police.

Similar incidents have been reported which shock us because so many people failed to respond to another human being who was in a "life or death" emergency. Why did no one help?

Two investigators, John M. Darley and Bibb Latané, devised several ingenious laboratory experiments which help to explain why witnesses don't respond to another human being in distress. The researchers believe that there are three things that a bystander must do if he is to intervene: (1) *notice* that something is happening; (2) *interpret* that event as an emergency; (3) decide that he has a *personal responsibility* for intervention.

In one experiment, college students were filling out a questionnaire when the re-

search staff fed smoke into the room through a vent. Two-thirds of the subjects who were alone in the room noticed it immediately, but only a quarter of the subjects working in groups of three saw it as quickly. Typically the students who were alone went over to investigate the smoke, and three-fourths left the room to find somebody to tell about the smoke. In groups of three students, the behavior was radically different. Here, usually once someone noticed the smoke, he would look at the other people, see them doing nothing, shrug his shoulders, and then go back to filling out the questionnaire. In the three-person groups, only three out of 24 people reported the smoke. Apparently, the inhibiting effect of the group was so strong that, rather than make themselves conspicuous by showing alarm or concern, most sat in the smoke-filled room, "coughed, rubbed their eyes, tried to wave the smoke away and opened the window," but did not leave the room.

In another experiment which involved no danger to the bystander, the subjects were engaged in a game and puzzle preference survey. The researchers used a tape recorder to simulate an accident in which the subjects were given the impression that a woman in the adjoining room badly injured her leg as she fell from a collapsing chair.

Here, again, the presence of other bystanders seemed to inhibit action. Of those who were alone when the "accident" happened, 70% offered to help the victim. When there were two subjects in the room together, only 20% offered to help. Those that did not intervene seemed to have decided that the event was not an emergency.

In a third experiment, an epileptic seizure was simulated. Many of the subjects who failed to respond showed physical signs of emotional stress, such as trembling hands and sweating palms. The researchers interpreted this behavior as a sign of indecision and conflict about whether to act or not.

Darley and Latané conclude, "Caught up by the apparent indifference of others, we may pass by an emergency without helping or even realizing that help is needed. Aware of the influence of those

around us, however, we can resist it. We can choose to see distress and step forward to relieve it."

For this work, the investigators won the award from the American Association for the Advancement of Science for the most significant sociopsychological research of 1968.

JOHN M. DARLEY AND BIBB LATANÉ, *When Will People Help in a Crisis? Psychology Today*, December 1968:54-57.

A Museum Is to Play

Instead of looking at glass-enclosed, "don't touch" exhibits at the new Visitor's Center of the Boston Children's Museum, children play with things in unusual settings, and probably learn a little. In one exhibit called "What's Weight?" different kinds of scales can be filled with pieces of sponge, wood blocks, pebbles, playing jacks, or spools of thread. A child can weigh himself by sitting on one side of a large scale and balancing his weight on the other side with vinyl-covered bags of sand or red and white cans of soup.

In the "What Is Size?" exhibit, a child can find out how big his foot is by putting it into different size cutouts. In an "Alice in Wonderland" setting, the objects on top of a desk are 12 times normal size, including a 12-foot ruler, a 6-foot high photograph, a 5-foot high telephone, and a 3-foot wide box of paper clips. One 5-year-old girl said that she liked the telephone best " 'cause you can climb on it and dial it and you can press down the button and if they ever hook it up, you can call on it."

The kids can make their own psychedelic light show by arranging pieces of colored plastic between two hinged mirrors. The reflections multiply and change as the mirrors move.

In "Grandpa's Cellar," boys can tune in an old crystal radio set while girls press clothes with an old flatiron. Inside an Indian tepee, the children can grind corn into meal with a pestle-shaped rock or try on Indian leggings.

Most of the credit for designing the exhibits goes to Michael Spock, son of the famous pediatrician, Dr. Benjamin Spock.

Maybe someday there will be exhibits about human behavior.

New York Times, January 1, 1969:14.

The Cold War Between the Sexes

Nobody questions that there has been a large increase in the employment of women in the United States. But has there been a change in sexual segregation on the job—that is, in the extent to which men and women have the opportunity to work side by side in the same occupation?

An analysis of census data by occupation, from 1900 to 1960, suggests that the great rise in the employment of women was made largely through the expansion of occupations that were already heavily female, the emergence of new occupations (such as that of key punch operator), and women completely taking over previously male occupations (such as clerks). A computed "standardized measure of differentiation" showed that while there still is a large amount of separation by sex in employment, there has been a small drop in segregation since 1900.

The male-dominated occupations have continued to exclude women or even to become more discriminatory. For example, there has been little change since 1900 in the proportion of women in professional occupations which have a large majority of men. However, the female-dominated occupations have become less segregated by sex and have allowed more men in their ranks. Nursing and social work are examples of this change. Where women are in the majority, men are frequently favored for the top administrative jobs.

EDWARD GROSS. *Plus Ça Change. . .? The Sexual Structure of Occupations Over Time. Social Problems, 16(2):198-208, Fall 1968.*

Skin Marking and Murder

Watch out for a tattoo on a man's body. A study of 99 persons charged with homicide at the East Louisiana State Hospital found that 33 had been tattooed. In contrast, only 12% of 200 general psychiatric

patients at the same hospital had a tattoo. Less than 2% of the women were tattooed.

Of the 33 tattooed patients in the violent-psychiatric group, 21 had a drawing of a heart on their bodies together with the word "Mom," "Dad," or "Mother." Two other cases had the heart tattoo and the name of the patient's younger sister. Ortho clinicians, you take it from here.

JOEL R. BUTLER, JOHN TRICE, AND KAREN CALHOUN. *Diagnostic Significance of the Tattoo in Psychotic Homicide. Journal of Corrective Psychiatry & Social Therapy, 14(2):111-113, Summer 1968.*

How to Get Rich

The median salary of the nation's psychologists in 1968 was \$13,200, an increase of 15% over 1966. Psychologists with a Ph.D or Ed.D averaged \$14,500; those with a master's degree, \$11,500. The highest paid were self-employed and earned \$21,000. The lowest paid worked on an academic-year basis in educational institutions and made \$11,500.

The data are based on answers to a questionnaire from 23,077 psychologists listed in the 1968 National Register of Scientific and Technical Personnel. The respondents represented about two-thirds of the psychologists who were sent questionnaires.

Psychologist Salaries Show 14.8 Percent Rise. The Washington Report (American Psychological Association), 4(9):12, December 1968.

Horror Story

A study of the Philadelphia prison system by the city district attorney's office and police department resulted in a sad and frightening report of frequent homosexual rape of male prisoners. Many "slightly built" young men who had just been admitted to prison were repeatedly raped by gangs of inmates. Some were forced to enter into a homosexual relationship with a single prisoner in order to avoid gang rapes. After a young man had been raped, he was frequently marked as a

sexual victim for the duration of his imprisonment. Physical beatings, threats, or bribery were used to get young inmates to submit.

The typical sexual aggressor did not consider himself to be a homosexual or even to have engaged in homosexual acts. He defined himself as male since he was dominant, but he regarded the passive partner as homosexual.

The victims had little faith in the ability of the guards to protect them from retaliation if they complained about other prisoners. Many guards discouraged complaints

from inmates or put pressure on the victims not to complain and cause trouble.

The report of the investigation was made public in September 1968, and since then some changes have been made to prevent sexual assaults in the city's prisons.

The worst of it is that the homosexual assaults in the Philadelphia prison are not unique but are probably happening every day in many jails and prisons over the country.

ALAN J. DAVIS. *Sexual Assaults in the Philadelphia Prison System and Sheriff's Vans. Transaction, December 1968:8-16.*

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LETTERS TO THE EDITOR

The Drug Issue

TO THE EDITOR:

As one of Dr. Harper's colleagues who is professionally concerned with youthful drug use, I take this opportunity to express my complete agreement with the position he expressed in his letter appearing in the April 1969 JOURNAL. It is indeed time for mental health professionals to speak openly against popular misconceptions, despite the possibility of adverse reaction from the public. I would like to add a point or two to what Dr. Harper says.

All too often mental health professionals restrict their focus to the individual who is presumably suffering from mental ill health; in this case the youthful drug user. Rarely do they concern themselves with the ways in which certain behaviors (such as drug use) come to be popularly or professionally conceived of as illness, the conflicting moral definitions given to such behavior, the various psychological and social effects of the behavior, the kinds of social control which may be applied to the behavior, or the legal and social warrants for exercising one or another form of social control.

The consequence of this restriction of focus is, as Dr. Harper puts it, a "defaulting of our responsibility." Our responsibility in this area is many-faceted and should be spelled out.

First, it is our responsibility to make available to the public our best information on drugs, information which will allay unjustified fears while focusing attention on legitimate areas of concern. And where information is lacking, we should encourage research efforts.

Second, it is our responsibility to distinguish between genuine illness and those forms of behavior which are conveniently labeled illness because they are antithetical to such major social values as industriousness. For example, many see marijuana users as being in need of treatment because they are said to lead an "unproductive" existence.

Third, and perhaps most important, it

is our responsibility to raise the issue of whether *any* criminal sanctions should be applied to purely self-directed behavior (even if there are potential adverse effects) and not simply assume that such sanctions are justified because they serve the mental health profession's interest in preventing individual ill health. The answer to this issue is not, after all, merely technical; it represents a profound moral and social judgment, and therefore the mental health profession must inform the law and not simply use it as an instrument to further its own ends. For even though the prevention and treatment of mental ill health are the bases of our professional enterprise, the use of criminal penalties to achieve these ends may have disastrous effects which far outweigh the dubious advantages.

Richard Brotman, Ph.D.

Professor and Director

*Division of Community Mental Health
New York Medical College*

Chairman

AOA Task Force on Drug Addiction

Are Treated Children Benefited?

TO THE EDITOR:

It is indeed a pleasure to read history of child psychiatry written with elegance and eloquence. But there is one part of Leon Eisenberg's "Child Psychiatry—The Past Quarter Century" in the April 1969 JOURNAL which calls for comment. He said that most studies have been unable to provide systematic evidence of benefit when the treated children are contrasted with those on a waiting list or designated controls.

A similar statement was made by Lee Lorick Prina in "Emotional First Aid?" in the *New York Times*, April 30, 1967. I quote: "A follow-up survey showed that 65 percent of the clinic children had improved significantly in the two years since

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PRESIDENTIAL ADDRESS

YOUTH'S CHALLENGE AND OUR RESPONSE: ARE WE A SICK SOCIETY?

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Western society—especially our North American society—has been variously characterized by different observers during our 69 years of existence in the twentieth century. The “Age of Analysis,” the “technological era,” the “child-centered era,” the “Age of Anxiety,” the “Atomic Age” have all been terms applied to this century. In our own country slogans such as the New Deal, the Fair Deal, the New Frontier, and the Great Society have been employed to describe the social and political thrust of programs designed to ensure economic stability and to combat the effects of poverty and discrimination, among other goals.

Over the last several years, however, it has become clear to many persons in our society, black, brown, and white, that progress toward a true state of what Dr. Martin Luther King referred to as “freedom and equality” has been agonizingly slow, with far more words than deeds. More significantly, the pervasive

pattern of white racism, based upon unconscious (or, too often, conscious) prejudice and an unwarranted assumption of superiority leading to exploitation of minority groups, has been jarringly but truthfully brought to light by the Kerner Commission and the statements of groups of militant minority persons. Rioting, draft-card burning and demonstrations, violence on university campuses, changes in attitudes toward sexual behavior, the use and abuse of drugs, changes in dress and length of hair, and other recent phenomena have led many to question whether ours is a “sick” society.

Without discussing the issues surrounding the “medical model,” with all its limitations—and perhaps a few assets—I would like to submit the view that our society is not “sick” in the sense that it requires a “miracle cure” from some societal therapist—whatever that may be. Although seriously conflicted, currently torn, and temporarily faltering in its cop-

DR. PRUGH was President of the American Orthopsychiatric Association, 1968–69. This paper was delivered at the Presidential Session of the 1969 meeting, New York, N.Y.

ing capacities (with admittedly lowered immunity to the virus of racism), I believe that our society carries within it the power of mastery over its perplexing problems. I am a grey-haired optimist (and, I suppose, still a starry-eyed idealist) with, I believe, good reason.

The "diagnosis" of the problems of our society has of course been made by wiser persons than I. The core problem seems to be the imbalance between our rapid technological advances and our relative lack of progress in interpersonal relations—the translation into everyday life of the disparity between the "two cultures" of the sciences and the humanities described by C. P. Snow. In spite of some encouraging trends, the dehumanizing effects of many recent technological developments are still all too readily overlooked in a society which is geared principally to competition, profits, and "free enterprise."

Among other signs, the credulous belief that computer banks of data in insurance, credit, police, and governmental systems will somehow produce "something of value" to society is perhaps the most tempting will-o'-the-wisp of the twentieth century. This is a view which ignores computer error and the possibility of misuse of the data involved, as well as the danger of the "faceless authority" which Kafka deplored. Overreliance on technological advances without stressing humanistic values can underwrite the simplistic use of military solutions for complex problems as well as the "arrogance of power," in our nation and others, which have been decried by Senator Fulbright and other thoughtful critics. Preoccupation with material goods and oversatisfaction with the "affluent society" can lead to easy denial of poverty in our land and,

especially, to unconcern with the evils of racism. Loose talk about "genetic programming" and "eugenic engineering" can support the avoidance of ethical issues and the dangers of "human engineering" in general.

These remarks are not meant to overlook the benefits of mass production and the raising of the standard of living as well as of certain technological advances—for part of the population—which have resulted from industrialization and capitalism. They are meant to put such benefits into perspective, however, when their side effects can include racism; poverty; ghettos in overcrowded and dirty cities; pollution of the air, water, and land; artificially homogenous suburbs; a lack of true national commitment to the physical or mental health of children; and a variety of senseless military interventions which are said to be "in our national interest." Perhaps Lewis Mumford best summarized our plight some years ago when he said, "Western society is caught up in a technological dynamism which is profoundly hostile to life."

My reason for optimism and faith in the capacity of our society to solve its problems and regain its balance stems from the attitudes, idealism, values, and vitality of our youth. Whereas our generation has spent most of its time trying to compete and gain position in a technological world, the new generation is primarily concerned with how they relate to our society. Beginning with their concern over civil rights under the leadership of Dr. Martin Luther King, and continuing with their engagement in the Peace Corps, VISTA, and other social action programs, and their involvement in the political process, to which Senator Eugene McCarthy was

one of the few adults to respond, the majority of our youth have demonstrated their commitment to change and their protest against "man's inhumanity to man."

In refusing to accept the status quo, they have rejected the bestiality and violence of war, and they have been unwilling to overlook or accept racism and poverty in our own society. They are posing essentially moral questions in their idealism and their social consciousness and concern. In so doing, they are reasserting the dignity of individual human beings and the importance of human values as against blind technological advance, such as the tour de force of expensive space travel while hunger and ill health still beset one quarter of our population. Their perceptions are acute, and they have picked up the inconsistencies and difficulties of our generation in adjusting to the newly articulated principles of civil rights and true freedom and equality—ironically, part of our original American dream—to which they react with anguished and outraged cries of "hypocrisy." They demand a different set of priorities—and they are right.

Some young people have felt these concerns so strongly that they have become cynical about the possibility of change in our time. A small percentage have "dropped out" or become "alienated"; the hippies and others have resorted to the use of drugs and other ways of attempting to find some sort of satisfaction with their existence or of escaping from a dehumanized society. Although we could wish that they would lend their energies to positive social change, we must face the fact that even their absence is a moral judgment on today's society.

Another small percentage of our youth have expressed their despair over lack of change by resorting to violence in the cities or in the universities. They have embraced a type of idealistic anarchism, reminiscent of the middle 1800's, which is based upon the belief that existing institutions must be destroyed and a fresh start made. Although we cannot accept their way of action, which is unlikely to produce the results they foresee, we cannot easily deny the validity of many of their goals. As Mrs. Coretta King suggested in a recent lecture, the restlessness of the students of today is the type of restlessness from which progress is born. As she further indicated, black students are the product of a paternalistic and racist society in which many have already lost faith, and they react out of frustration and bitterness. The same is increasingly true of students and young persons from other minority groups such as the Spanish-surnamed and the American Indians, who also have not as yet found their rightful place in society. Young people from each of these groups are beginning to forge identities of which they can be proud, and are rightfully demanding justice, responsibility, dignity, and true equality.

As mental health professionals alone we cannot solve the crisis of racism, purge our country of violence and bitterness, remove the scourge of poverty, nor erase the blight of our cities. We can make certain contributions, however, as mental health workers and as informed citizens, to changes in our social and educational institutions which can permit our deeply concerned young people to play a vital role in determining the destiny of our society—which must soon become their society.

Our generation can begin with rec-

ognizing that young people have grown up under a totally different set of circumstances than we faced at a similar age. Although they have performed at segregated schools, they have been aware that since 1954 these were against the law of the land. Also, as pointed out recently by Professor Wald, they have had to grow up facing the fact, in our nuclear age with its overemphasis on military preparedness and expenditures, that they might not have a future at all. In addition, the "generation gap" has been influenced by the effects of the mass communication media, which were not a part of our youthful experience. Finally, our generation must admit that the upsurge of social consciousness and concern has caught us unprepared for its inevitable consequences.

But the two generations do have some core values in common. In a sense the new generation is reasserting the traditional values of human dignity, freedom, and equality which our generation has taught them, out of our own heritage, but to which we have largely given only lip-service—and the young people know this. We must, therefore, develop channels for open and honest communication between our youth and older persons, in the family, the schools, the universities, and in society, which will permit constructive dialogues to take place.

On our side we can offer some experience and, hopefully, some wisdom and leadership to which youth can respond, as did for example Dr. Martin Luther King and Senator Robert Kennedy. We must, however, open our ears to youth and respond to their confrontation, taking seriously their demands for relevance to today's world in their educational experiences and for some responsible

role in determining the goals of education and the direction of social change. Most students do not want to take over and govern a university, but they do want—and should have—a positive response from the administration and a voice in determining its policies and curriculum. Most black militants do not want to run the police force, but they do want—and should have—a response involving respect and a mutual interchange of ideas regarding the handling of protest and violence. Only through new mechanisms for communication and shared responsibility—and not through repression and counterviolence—can a stabilizing effect be exerted upon the rapidly changing styles of thought and behavior in our social and educational institutions. Until such mechanisms are developed—and only we of the older generation can offer them positively—social upheaval will continue, and constructive change will be seriously limited.

Those of us who have been fortunate enough to be involved in such mutual interchanges of ideas realize how much we—and society—have to gain from the contributions of youth. In my own experience on a student-faculty council in a medical school setting and with high school students on a community relations council, the young people involved have offered positive and constructive challenges, exciting new ideas, and an admirable impatience with administrative, community, or national dilatoriness in bringing about change. They will not accept tired old explanations that "qualified" minority group students cannot be found or fostered, that curricula cannot easily be changed, that school integration will take many years to accomplish, or that the peace-time draft is inevitable.

Their energy is boundless, their idealism and candor refreshing—though sometimes somewhat embarrassing to us—and their wealth of new ideas exhilarating, even if at times so many suggestions for change can be anxiety-provoking to members of our generation. One can see that we do have something to offer youth out of our experience, such as the awareness, in the words of Mrs. King, that “in building a new age, the old should not be destroyed but built upon.”

Perhaps our greatest contribution as mental health workers, in addition to helping troubled youth directly, can be in aiding institutions and agencies in our society to move toward a less rigid structure and to devise channels of communication and shared responsibility. We can also help parents to face confrontations by their children with less anxiety and greater honesty and to understand that giving material goods is less important than giving respect to youth. Before we can offer help to others, however, we must give young people greater responsibility in our own agencies and in our professional organizations. These are steps that are new and uneasy for all of us, requiring humility and respect for the contributions of those who clearly can do many of the things we older professionals have thought only we could do. No matter

what we profess, it is painful for us, as middle-aged persons, to abandon the status quo. As the Chinese philosopher, Lao-tse, said in 500 B.C., “In order to understand the evil in others, one must first understand the evil in one’s self.”

A young black psychiatrist in training at Harvard, Dr. Robert Sharpley, wrote recently, “The overwhelming task of our time is to make kindness explicit, not only among individuals of different ethnic and racial groups, but among nations as well.” In my opinion, this is not unrealistic idealism from a young man but deep and desperate truth. His inclusion of nations echoes the recent remark of a Soviet scientist in the *New York Times* to the effect that if our world is to thrive, we must eliminate the “egotistical, narrow-minded approach to relations between nations and races.” I would add that unless we become citizens of the world and thus transcend the national state, we are in dire danger of destruction.

As Dr. Sharpley noted, efforts to make kindness explicit, at any level, will require much patience, understanding, and effort—but “the alternative is chaos.” With youth’s idealism and commitment to help us, we can say, in the words of the poet, Robert Bridges, that “our hope is ever livelier than despair.” In my belief, truth—and youth—shall overcome.

THEORY AND REVIEW

VIOLENCE AND COUNTERVIOLENCE: THE NEED FOR A CHILDREN'S DOMESTIC EXCHANGE

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What is commonly talked about as black violence in this country might more accurately be described as the black's counterviolent response to white violence done to him. This paper analyzes the many forms of white violence, uses the suicide analogy to understand the current stage of black counterviolence, and proposes a remedy that conforms to the "living law" habits of the American people.

Violence is a very complicated subject in America but one which has a known solution. The solution is easily stated: eliminate white racism in the United States. Once this is done all forms of violence, including nonracial violence, will be so minimal that the society can preserve itself. The penalty for failing to reduce white racism in America is so awesome in its probable manifestations that the entire world is threatened.

It seems therefore that the task for

professors and intellectuals in America is to find ways by which white racism can be eliminated. Implied in this charge, of course, is the need to make America so aware of the consequences of white racism that all citizens believe it to be in their own interest to apply whatever effort and resources are required to eradicate violence from this society. This paper proposes one specific that could be included in the education of each citizen in a relatively inexpensive and casual manner, which would work toward this

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objective. Before discussing this specific, however, I would like to make a fairly lengthy position statement about factors

producing the climate for white violence and the invitation to black counter-violence.

SUSTAINING AND PROMOTING VIOLENCE

In my opinion inestimable harm as well as undeniable good has come from academic conferences dealing with the problems of racial violence. There are diverse roots for the harm. The strongest harm-root grows from the fact that these conferences almost inevitably have whites talking about how it is to be black. Black social scientists obviously have no greater access to truth. However, the very fact that they have survived in white America indicates they will have a different fraction of truth than the whites, particularly in reference to race problems. Further, it is well known in ghettos throughout the land that white researchers are "put on" by the ghetto citizens. This matter of data accumulation is not eliminated merely by whites having black assistants or colleagues. There can be little doubt that the presence of a single white drastically changes the group dynamics of blacks. For instance I once observed a researcher come into a black barber shop. Prior to his arrival things were in their customary vibrancy and aliveness. The moment the white researcher arrived the entire group became sullen, sluggish, laconic. This man could have drawn the correct conclusion from his observations that the men here were dull and uninterested and uninteresting. But of course the conclusion would have been correct for only the duration of his observation. The tragic point of all this would come when the "findings" were disseminated at conferences, in scholarly journals, and through the mass media. Thus results an undue focus on black psychopathology rather than on white

racism. It permits even liberal whites to feel sorry for blacks but not to truly incorporate the fact that their concern should be less on "what blacks are" but more on "how we have made blacks." It is easier to be sorry than to be responsible. Responsibility generates far greater action than pity.

Related to this great harm, of being sorry instead of responsible, is another which has wide currency in our land. It is extant and probably will remain so because it does feature a perhaps universal attribute of the human kind. This is the idea that the problems in the United States are more class related than race related. It is comfortable for whites to think the black's troubles come about because he is poorly educated or impecunious or uncivilized. Such thoughts obscure the true basis for the tensions in America. The true basis is directly a function of skin color. Any person who thinks otherwise has never known of a rich black man denied a club membership; nor has he heard of the world-famous celebrity whose color kept him out of a hotel; nor has he witnessed black men, acculturated in the finest schools in Europe and the United States, get their heads whipped during racial protests; and of course, he has forgotten that even the son of a Nobel Prize winner or the wife of a former ambassador cannot play tennis at places where their white counterparts would be accepted without question.

In essence what this says, which is germane to how violence is sustained and encouraged, is that whites are better

than blacks and therefore can take prerogatives and liberties with blacks that they would never dream of taking with whites. Since this is the true and often official posture of white America, it means that the collective majority condones and teaches any individual white child that he can be depreciating (and therefore violent) to any black. It means in all likelihood that just as there has never lived a black in these United States who knew freedom, there probably has never lived a white who has not had ready a line he'd draw against blacks. Some fortunate whites may have never had to exercise this line. Others don't see it when they do draw it. Or they indulge their fellows when the line is drawn for them. Witness a liberal white friend who complained to me what a damn shame it was that blacks couldn't stay at the New York A.C. He said that the last time he stayed there he thought while he was riding on an elevator about all the "nice Negroes" he knew. Thus the ingredients of white racism, inculcated into virtually every white child, which do violence to black people are feelings of superiority, exploitation for self-gain, ready degradation, abuse, and dehumanization of people whose skin color is different. Yet the most dangerous ingredient is one which encourages whites to ignore the presence and/or sensibilities of blacks. That is, all decisions can be made without consulting the black community or black individual.

Since virtually all whites are involved, the largest public health and mental health problem of the United States is racism. Several black psychiatrists were able to give these ideas to the Kerner Commission before they released their report. Our belief confirmed their own. We indicated that a public health prob-

lem is one which: (1) affects masses of people, (2) cannot respond to one-to-one treatment methods, (3) results in chronic, sustained disability, and (4) requires large sums of money to eliminate.

Because racism involves virtually all whites and is insistently and persistently included in the education of all whites, it becomes a massive mental health problem. For the basis of the racism is a mental attitude about skin color. It is by definition delusional since it is an irrational idea born of morbidity which is refractory to change when contrary evidence is presented. In previous publications I have dwelled on some of the psychology of being black.⁶⁻¹¹ For the purposes of this paper I'd like to mention one set of mental mechanisms which contribute to the delusions of racism which sustain white violence to blacks.

In dealing with blacks, whites have been cued to use these three mechanisms, usually sequentially, although often simultaneously: (1) denial, (2) dilution, (3) projection. In nearly any negotiations with blacks the white first of all denies there is any problem worth confronting. If there is grudging acceptance of a confrontation, the white minimizes or dilutes its significance. With further interaction the white projects some uncomfortable or devaluating component onto the black. The end result is that the white can continue his delusion of superiority and at the same time act in such a manner that the hapless black does in fact sustain the white delusion that he is so dehumanized that it makes no difference to ignore him or abuse him or violate him. Therefore it happens that whites can act with impunity toward the powerless blacks and yet not suffer conscious shame, guilt, or remorse.

Let me illustrate this point by a couple

of experiences I endured in the last few weeks while a consultant to an extremely liberal group which was working hard and effectively on behalf of disadvantaged black children. The scope of the group's work required both academicians from many disciplines and various creative artists to be present. In each of the two meetings I'm about to describe, there were three blacks and perhaps 30 whites, even though a primary stated objective for the meetings was helping black children. At the first meeting I noticed that *each* time any black spoke there was a swift chorus of "yes, buts" and "you haven't considered this. . . ." The three blacks present talked about this phenomenon since it was so painfully apparent to us that whatever opinion we ventured there was always a qualified dilution and/or negation. Even after we blacks had discussed this amongst ourselves and had agreed to observe carefully, the pattern continued. Needless to say we recorded very few instances where a white speaker was similarly discounted with such haughty condescension.

In the second meeting the format involved allowing each professor present to give his ideas before the meeting broke up into small groups. You can guess which professor was the only one who was not called upon to present his ideas.

Here then in these meetings amongst a cooperative, well-meaning, and enlightened group, the black people could be denied. If they ventured opinions they could predict that the opinion would be minimized and qualified. And as whites listen to this they will project that the blacks are too sensitive. Yet I report this common mental mechanism of "denial-dilution-projection" because it has enor-

mous implications in all communications between black and white. The black can feel nothing but anger at being incessantly violated in this manner. The white, protected by an ego defense, cannot understand the exquisite sensitivity and certainly would be reluctant to term this violence. So the delusion continues. But at this moment in history the black is telling white America that although we've been involved in a *folie à deux* or double-madness, the black will no longer facilitate the white man's half of this insanity. Black people will no longer permit whites to believe that blacks are willing and happy to be subhuman. Blacks resent being the targets for violence. A pressure of social events makes it now possible for blacks to retaliate with counterviolence. Whites are incredulous that blacks would enter on such a suicidal path. The pertinence to a suicide analogy will be taken up in the next section of this paper.

Conscientious and concerned whites are perplexed. They offer more and more programs. Their delusion prevents them from accepting a crucial consideration, namely that changing attitudes is more important than providing programs. As a result of this mental block, whites generally fail to see the importance of relating white racism to the total overhaul of America's institutions. So while white America thinks up more programs about jobs, education, and housing, black America is increasingly anxious to redo the process by which institutions operate. Only then can the programs succeed.

As long as a \$50,000-a-year black can be disparagingly addressed by his first name by a \$10,000-a-year bank employee, there will be a surge to counterviolence. As long as government institutions conduct affairs directly re-

lated to black people without black consultation, there will be a surge to counterviolence. As long as less than ten percent of the money spent in the ghetto recircularizes in the ghetto, there will be surges to counterviolence. As long as important mass media such as all the television stations of the United States are bereft of one black policy maker, then there will be surges to counterviolence.

In fine, what I am trying to say is that a program of housing or job training is doomed unless attitudes change sufficiently for institutions to provide black men with respect and dignity. Inherent in this respect is the condition that blacks should have a voice in their own lives. The attitude changes are required at every level from the one-to-one manner in which any black can be maltreated to the corporate policies which dictate that no black can rise too far above the menial stage.

It is for this reason that the person who most sustains and encourages the cycle of violence and counterviolence is the man who makes more than \$25,000 a year. It is the privileged white who could change the attitudes of his institutions. Let there be no mistake about it: the more privileged and the more powerful a man, the more responsible he is for the racial tensions in this country. Popular opinion sees potential open conflict between the poor black and the lower-class white. In truth these are the likely combatants, but the responsibility for the conflagration which could have such profound influence on the whole world will rest more with the white chairman of the board than the white taxicab driver. The action of devastation to property and persons by poor blacks and white factory workers will be due to the

lack of action by white senators. The paralysis of America's great cities will not be the result of the fears of white clerks but the refusal of white corporate management to change attitudes about the way individual blacks are regarded and the way blacks as a whole are given opportunity in the company.

There remains to be discussed a grim conclusion concerning the factors which perpetuate the ugly cycle of violence-counterviolence. The mentality required to deny, dilute, and project in relation to blacks becomes so ingrained in the American majority member that the same mental mechanism becomes handy for other sorts of interactions. Well-intentioned white Americans can't understand how so many of the world's people come to harbor hatred or resentment for America. To be able to deny that one is violent to blacks is the first step to being deluded concerning one's treatment of Vietnamese. To be able to dilute the human problems in the ghetto is the first step toward minimizing the effect of sending one's troops into Santo Domingo. To project concerning the black man's essential danger is the first step towards forcing an arms race with another superpower. To ignore blacks is the first step toward failing to give official recognition to over a third of the world's people.

For the black victim the conclusion is equally grim. Oppressed, defeated, demoralized, and degraded in a hundred ways each day of their existence, many blacks come to accept low esteem; and their brothers, hopelessness and helplessness. The black's daily existence is controlled by others and always not far in the background are the police. Since the police act with the total community's acceptance, the black realizes that for him the state is a police state. Regrettably

one can ask ghetto children any question and in a disproportionately large number of instances the immediate reply includes the police. Ask a group of teenagers, for example, why they don't do such and such. The answer is, "the police won't let us get together to meet." Ask a preschooler what he'd like most and he might answer, "to have the policeman come and put so and so out of the house." In formulating neighborhood plans there must be automatic allowance for police surveillance. Thus the black comes to see himself controlled and inhibited as well as degraded and demoralized. Bereft of hope, despairing of surcease, many blacks are understandably depressed even if they lack vegetative signs of despondency. For them survival in a police state is miracle enough.

For the white majority member the question should be asked, if a tenth of the population exists in a police state, is the remainder of the state really free? The answer might be framed in terms of that old clinical saw about having a touch of pregnancy or a touch of cancer. Such an answer is apt, since if one permits the police state in a democracy the spreading effect is similar to the spread of cancerous cells. If on the other hand one banishes all vestiges of a police state from a democracy, then there is opened the possibility for a rebirth of the nation's vitality.

In order to review this section of the paper I would like to state some of the aspects that a solution to the violence-counterviolence cycle would have to entail. It is theorized that more emphasis must be placed on the effects of white racism. But any plan by a psychiatrist should take into consideration the tenets of psychodynamic theory relative to the

etiology of race prejudice. This has been done by many but I would cite the work of a black psychoanalyst, Dr. Charles Pinderhughes,¹² as being particularly relevant. Another feature of any plan must be that it would help reduce the public health and mental health hazards of racism. This means the plan must be capable of affecting great masses of people rather directly. At the same time it must work toward eliminating the way whites perceive of blacks and thus permit negotiations by denial, dilution, and projection. The plan must provide hope to the depressed blacks, and it should be concerned with changing individual and corporate attitudes. It is submitted that if the question "what can I do?" is answered sincerely and genuinely by all people of good will who see it in the best interest of the country to banish racism, then a plan could be actualized.

Lamentably, current events oblige the armchair theoretician to calculate that these persons of good will are becoming disenchanted and disaffected by events in the ghetto. Cries are raised about "violence." To many persons today violence means unrestrained lawlessness by blacks. This puts an onus on the blacks for doing something shameful and sinful. In reality the cry should be about "counterviolence," since the black is reacting to the several hundreds of years of unabashed and unrelieved violence that has been visited upon him by white America. Accordingly, any national plan must be equally preoccupied to stay both violence and counterviolence. Thus we turn to a consideration of black counterviolence. Once we attempt to understand counterviolence as we have violence, then plans might be made to break the dreadful cycle.

COUNTERVIOLENCE: A RECOURSE TO DISSATISFACTION

To understand black counterviolence to white violence we must return to the suicide analogy. No thinking person can see how a powerless, defenseless, terrorized minority could retaliate against the people of the most powerful nation the earth has ever known. Isn't it folly? Isn't it suicidal?

THE MEDICAL MODEL OF THE LIFTING DEPRESSION

All clinicians have been taught that the time of greatest concern in managing suicidal patients is not when they are in the depths of their depression but when the depression is lightening. The chance for a successful suicide attempt increases during the phase of "lifting depression." Without resorting to a protracted defense of why blacks feel less depressed, let me hypothesize that black America is in a phase of lifting depression and thereby is in similar danger to that of an individual patient coming out of his depression. Apt comparisons can be drawn between the suicidal patient's psychodynamic and the feelings of black America.

What this means is that the collective blacks no longer are introspecting the negative attitudes about themselves that white America has projected onto them for centuries. There is a marked reduction of self-abasement and corollary feelings of worthlessness and uselessness. Therefore there is decreasing self-punishment and a decreased willingness to accept one's miserable lot. As a result, powerful emotional vectors are now not only rejected but they are projected back onto white America. Blacks are desperate. Blacks feel there is nothing to lose. Blacks savvy that white America from its early pioneer days has always

permitted and rewarded the strong, the daring, the assertive, the independent. Black writers remind us that we are still in bondage and the reader concludes that the great shame is only that we have been so passive in accepting this servitude.^{2, 8} Having nothing to lose but shame, blacks are now in ever increasing soul-searching about "taking the final step." Just as the suicidal patient musters courage and blocks off vacillation, I can now in honesty and urgency indicate that I have attended meetings where the summary statement is, "Brother, we just have to come to the final step."

So the answer to the question "isn't it suicidal?" is affirmative. However, the answer to the question "isn't it folly?" is negative. To defend that answer I need not present the philosophical attitudes of blacks who believe that an all-out effort to exchange our sorry plight to become full citizens is more than adequate reason to risk everything. After all, as I've noted, blacks feel, correctly, we have nothing to risk.

Yet if I were a white man in 1969 I would calculate what I had to lose if the black minorities who occupied my inner cities felt so desperate that they are now in a dangerous phase of a lifting depression. No white in America needs to be reminded of his superabundance of creature comforts. Nor does he need to be reminded of the enormous opportunities that this country provides for him economically, politically, socially, culturally. What the white may need to be reminded about as he contemplates black counterviolence is that perhaps there are now enough educated, dedicated, and trained blacks who if organized could in fact disrupt the economy of this nation. If I were a white man I would consider

whether a desperate minority, which even now occupies itself with lectures on urban guerrilla warfare, could find ways of destroying masses of white citizens and white property before it was annihilated. Would this aroused enemy minority be any less difficult to handle in the streets of the United States than it is to handle the Viet Cong in the jungles of Vietnam?

It may be instructive to follow the suicide analogy a bit further in order to appreciate black counterviolence. Let us consider a few of the reasons that the person in a lifting depression might be able to decide to take the final step. Like the black, many suicidal patients believe that the world has dealt violently and unjustly with them. Both groups respond to feelings of being irrelevant and frightened. Both groups are angered over arrogance and double standards that they believe others communicate to them.

COUNTERVIOLENCE FROM FEELINGS OF IRRELEVANCY

All humans need to feel that their existence is justified. If the human or the group of humans see their reality as preventing justification of existence for reasons not of their own making, then they are caught in an inextricable web. They can't justify their existence yet they can't do anything to ameliorate the situation. The psychological end result is despair and depression. One can turn off or accept defeat. No matter which is selected, no matter how graciously it is selected, there must be an accompanying taste of bitterness.

Blacks have long felt trapped in not being able to justify existence yet not being able to correct their condition. So they have been depressed. Yet now there

is, like there has never been before, some hope that existence could be justified. A host of social and historical circumstances have allowed sufficient attitude change by white America that it is now at least legally possible for a black to cherish some hope.

Mundane issues of manpower shortages and economic buying power have played a role too. Thus for the talented or educated black new vistas now appear. At the same time, for the great masses of blacks life becomes more harsh. Compared to the white, the black is not increasing his standard of living nearly as fast (and of course he started at a much lower level). Compounding all this is that technological displacement has broadly and adversely affected countless urban and rural blacks. Yet all those so damaged realize that nowadays blacks do have an opportunity. Thus the damaged person cannot as easily console himself that every other black is in the same bag. But the damaged person is aware of the handicaps, perpetrated by whites, which prevented him from being able to actualize hope when it is presented. So while hope is in sight the person comes to feel more hopeless, more irrelevant.

COUNTERVIOLENCE FROM FEELINGS OF FEAR

Every physician is well acquainted with the cause-effect relationship of fear and violence. It is well known that those creating danger for themselves, for others, and/or to others' property are often driven by fear.

White violence in all its forms, from brutal, senseless lynchings to community sanction for establishing a police state in black ghettos, has resulted in much and well-founded fear in the black com-

munity. Any black citizen in the United States, in order to function, must have a hyperaware, hypersuspicious, hypersensitive attitude about how whites will treat him. He must never lose sight of the fact that, for operational purposes, all whites will somewhere draw a line against him by virtue of his skin color. This interpretation of reality, if consistently applied, will allow one to survive. Lapses in such an interpretation can be literally fatal.

A moment's reflection will indicate that the wonder isn't that blacks are now becoming serious about counterviolence; the wonder is why, under the duress of such magnificent terror, blacks never before inaugurated a massive counterviolence. But now as people become more literate they realize that to be irrelevant, hopeless, and frightened without exerting stronger resistance is to subscribe to extermination or at best to be in famine amidst a land of plenty. Accordingly, as matters now stand, strong repressive measures probably will be instituted against the blacks in the not too distant future. It seems predictable that the more fear-provoking the tactics of this repression, the more counterviolence white America can expect.

Many whites scoff at the possibility of instituting repressive laws. Yet this is what over a third admit to in a national poll⁵ when they say, "kill rioters." There seems to be a double response coming from white America. On the one hand the message is clearly repressive, on the other hand there is a cue which verbalizes that repression is impossible. Blacks have lived for decades in an America accumulating such double standards. America, while proclaiming itself to the world as the standard bearer of democracy, has never ceased practic-

ing the worst antidemocratic techniques to a significant proportion of its population which it deemed legally disenfranchised.

Let us turn to these double standards as another source of black counterviolence.

COUNTERVIOLENCE FROM REACTION TO DOUBLE STANDARDS

Again the clinical paradigm will be used. It seems likely that a person given a constant barrage of double cues or "double binds" can be directed into serious mental illness. Pavlov even bugged his dog by not letting the poor creature know if he was dealing with a circle or an ellipse. If blacks have been insane to accept inhumanity from whites as a price to live, they now see that the cost is too dear. The resolution is to have clear standards. This requires not rebellion but revolution. A reformation of institutional attitudes is necessary. If only one point is recalled from this discussion let it be this: whether or not the revolution will be bloody depends on white America. Repression is one definitive cue. However, that will lead to engagement. Unadulterated equality is the other definitive cue and the only one the black will entertain.

There are numerous double standards in the United States. For purposes of citation I will pose one which particularly infuriates black men. This has to do with subsidies. Blacks are not concerned about subsidies as such but feel that the publicity given over to welfare as a form of subsidy makes the Negro out to be a leech on the economy. Very little is said about subsidies to the affluent. I now quote from a 1968 conference of the U.S. Senate Subcommittee on Government Research:

Why is it that subsidies to the poor are considered drains on the economy when subsidies to industry are considered economic boosts . . . ? There is a welfare system in America for the rich, too, and it far exceeds anything the nation has ever considered for the poor. The cotton industry, for example, has in the past two years received \$1.8 billion in subsidies. That \$1.8 billion goes largely to the corporate and wealthy farmers who receive a subsidy over a two-year period equal to the cost of the poverty program for a year. The petroleum industry alone receives \$9 billion annually in government subsidies. In 1962, the value of tax write-off allowed the middle-class and wealthy homebuilder for mortgage payment interest equalled twice the amount spent on public housing.¹⁴

There is no need to recite other statistics from industry, transportation, or agriculture. Counterviolent feelings are provoked when a community is enraged that double standards of judgment are focusing undue and negative attention on it. From the black viewpoint this is a continuation of other injustices in the society. Daily, in ghettos across the country, black brothers exchange the Black Power handshake and commiserate over such injustices of double standard as a 12-year-old petty larceny looter being shot dead on the streets while a white who embezzles millions of dollars is placed in the deliberately genteel surroundings of a special federal prison.

Mentioning black power leads us into another friction point of double standards which promotes feelings of counterviolence. For years whites have stated that blacks should want to help themselves. When blacks themselves began to state the same thing it became untenable to much of white America. Once more the black is placed into an inextricable posture. He is asked to do something but as soon as he undertakes the assignment he is greeted with appalling chal-

lenge and rancor. Much of this sort of difficulty is referable to semantic confusions and obfuscations which stimulate defensiveness by both races. As a result the equilibrium of violence-counterviolence is merely speeded up rather than retarded.

Numerous examples of this sort of confusion can be listed. Black extremism, black nationalism, black separatism, and black power have been lumped together in the minds of many people. This presents grievous obstacles in discussing concepts and forming ideas which are prefatory to intelligent action. As long as communication blocks exist and individual feelings are "uptight" about these concepts, feelings of misunderstanding (due to semantic confusion) contribute to urges to violence and cross-violence. The policy-makers and executives of the mass media must be evaluated in the light of either innocence or guile in letting these different concepts become overlapped and equated with each other. Due to the psychology of condensation, each concept appears equally unsavory to the total society.

Other examples of semantic confusion which lead to double standards in the white and black sectors include the concepts of riot, welfare, violence, law, and order. Rightly or wrongly, blacks have come to believe that whenever these concepts are used they are thinly veiled vehicles to express, almost euphemistically, negative and anxious attitudes about the black community. Further, the concepts are used in such a context as to make the black community culpable and therefore deserving of harsh treatment. It follows that since the blacks, again rightly or wrongly, fail to acknowledge culpability, the only recourse is to prepare to meet the expected new and more savage harsh

treatment. So continues the urge for counterviolence as a defensive measure against presumed attack.

COUNTERVIOLENCE FROM REACTION TO WHITE ARROGANCE

The schoolboy who has fantasied retaliation against the local bully has made the same conclusion as the clinician who has observed that translation of a disagreement from fantasied or verbal level to the level of overt aggression is usually precipitated by an ego insult. Pride, the sin the Greeks considered the greatest, is what motivates the psychologically castrated male to uxoricide. It is to defend pride that street gangs preserve their turf or territory.

All the urge to black counterviolence can be summarized by saying that black pride has at last reached the stage that white arrogance becomes insufferable. Even being mindful of the Greek admonition that in pride's wake comes nemesis, blacks are becoming more willing to make the suicidal gamble for the victory of democratic equality or the grand loss of genocide.

The desire for counterviolence leaps into one's soul not because one's neighborhood is to be renewed in order to make luxury apartments and expensive office buildings for the affluent. The desire for counterviolence intrudes itself because of the manner in which you are forced to find new lodgings, new friends, a new job. There is no dignity or tenderness or consideration offered. Your sensibilities are roughly disregarded or kindly ignored. You are denied the elemental courtesy of even being considered to have sentiments.

The desire for counterviolence doesn't leap into one's soul because one's children must go to ramshackle, crowded

schools. One comes even to tolerate the doors being locked, putatively to keep teachers from being attacked. The desire for counterviolence intrudes itself because of the way you are demeaned, ridiculed, and actually laughed at by school administrators when you attempt an audience about the curriculum. Your complaints are minimized and it is communicated to you that you should be satisfied with a crumb while the communicator tells you by his attitude that both a loaf of bread and a cake are not sufficient for his kind, the superior ones.

The desire for counterviolence leaps into one's soul not because one must be unemployed or underemployed. The desire for counterviolence becomes insistent because you know that no matter what you do to improve yourself you are still severely limited and still not wanted. You are irrelevant and hideous in the eyes of the world in which you live.

The desire for counterviolence comes when contemplating the condescending, patronizing and stereotypical attitude that whites have concerning welfare. Yet it is true that most of the people on welfare are children, the aged, and the disabled. For instance, 67% of those on New York City's welfare rolls are under 16. America spends 0.6% of its gross national product on welfare.¹⁸ This is a figure much below any other major western nation's. A security officer friend of mine alleged that according to figures of insurance claims, pilfering in stores, mostly by white employees of course, amounted to about 0.2% of our gross national product. How much more was pilfered without coming to the attention of the insurance authorities? When this 0.2% pilfering figure is contrasted to the 0.6% welfare figure and account is taken that since over half of the poor in

the United States are other than Negroes, it becomes even less impressive about what is being given to the black. And of course it is pointless to compare it with what is given to big business.

Black men in the streets are learning these sort of figures. They discuss them and don't feel there is a need to be made

to feel apologetic. In the meantime increasing attention is being paid by blacks to how blacks organize themselves and what are the ways they can better understand white America.^{1, 15, 16} Blacks are communicating with each other like they never have done in the past. But what of the future?

THE PROJECTED FUTURE

Relative to formulating a plan to halt the violence-counterviolence cycle, it is necessary to project some aspects of the future. The salient consideration is that well into the next century it would seem impossible for the ghettos to be razed. Today over 86% of blacks live in segregated housing. By ten years from now the percentage will be in the 90's. Much of this housing is substandard. In essence these figures give a statistical description of the ghetto.

Demographically it would require moving half a million blacks per year, starting today, just to keep the ghettos the same size as they are now. Even if white America had a sudden change of heart and wished to accomplish such a migration, how would it be done? Where would the blacks live in the suburbs? Where would they go to school? Where would they work?

Doubtlessly, marvelous new technology will be forthcoming in the next few decades that will revolutionize the construction industry. Even without total knowledge of what these new materials, methods, and machines will be, America is planning to redo its housing in the next 35 years. Yet 90% of the housing construction in the next quarter of a century will be in the suburbs. As a result there will be little new housing for the blacks who will be concentrating in ever larger numbers in older and older

housing. Added onto these factors is the consideration that ever more of the inner city must be given over to highways, parking spaces, aqueducts, etc. Thus more and more blacks will be squeezed into tighter and tighter, essentially segregated ghettos, into older and older substandard housing. This cauldron of increased polarization, when stirred with the other social dissatisfactions which compel urges to counterviolence, can be assured of being explosive unless remedies are attempted.

The white violence/black counterviolence cycle has been discussed at such length because a fundamental principle is that any practical plan must, for a considerable short run, conform to the "living law" habits of the majority of the people. What we have been discussing have been some of the psychological factors in the living law. The living law is described as the spontaneously held beliefs and social habits and behavior of the people.⁴ The living law is what most people would do even if there were no positive or written law.

Thus the plan which is to be described tries to fit the psychology of the present living law as it has been delineated. It aims to be expedient. For as the ancient Stoics held, men are best instructed by expediency, since necessity is always man's teacher. Intrinsically bound to

necessitas are two other principles which guide the formation of a plan. These are *utilitas* or utility which considers the

functional aspects of things and *cosmopolitas* or the consideration of the common good.

THE CHILDREN'S DOMESTIC EXCHANGE: THE CDE

The proposed remedy must be something within the living law. The question always asked after discussions of race is, "What can I do?" This question is asked by individuals as well as by private and public agencies and institutions. Moreover, whatever is done, the individual or institution must feel it is doing what it wants to do, when it wants to do it, and how it wants to do it, and that it is doing as much as it chooses to do.

If white and black citizens in a polarized society are to ever integrate and cooperate for their mutual good, they must first have some contacts with each other in order to decrease feelings of strangeness and animosity. They must through natural processes rub down each other's angularity. And even though attitude changes come slowly, there must be the possibility that heightened awareness and sensitivity to each other's problems can be fairly rapidly acquired.

In short, an educational process is called for which provides an ongoing possibility to influence masses of citizens. The CDE is a theoretical program which if actualized by a national thrust might be one way of influencing sufficient numbers of people that violence-counterviolence would be retarded.

The program calls for children of *all* socioeconomic and racial persuasions between ages 10 and 18 to be given travel grants. Ideally, each child would travel at least once a year as part of his education. The essential is that each child would travel always to a situation distinctive from his own cultural background. The white from Darien, Con-

necticut might go to an Indian reservation. The Mexican-American from Los Angeles might go to a farm in Ohio.

The plan would require a staff cadre modeled after VISTA or the Peace Corps, which would coordinate and administer the program. A chief function of the staff would be to individualize and customize the program for each child, depending on what his needs are and what contributions have been made by the public and private sectors. Advisors have assured me that modern communications and computers will make possible the administration of the program. Thus it would not be anything like sending a bulk of slum children to an exchange site for a period of time.

For the adults and children who volunteered to do what they could, there would not only be feelings of satisfaction but transcultural, transethnic experiences that would broaden each of them and facilitate meaningful attitude changes. For the child participant, there would be the opportunity to learn more about the world and the people in it and at the same time to obtain the satisfaction of assuming progressive responsibility for himself. All the participants could widen their vocational aspirations, a tangible step toward hope.

GENERAL SCHEME

The italics in this description indicate a volunteer contribution:

J. R., a 12-year-old from a Mexican slum in Oklahoma City, is sent for three days to the home of an upper-middle-class *black resident* in New Jersey.

American Airlines offers one of their seats. *Professor B.*, on his way to lecture in New York, accompanies J. R. *Professor B.* has the assurance of *Dean W.* that overhead expenses from a *National Science Foundation* grant will defray hotel or other costs for J. R. if it is needed. However, upon arrival in New York, J. R. is met by *Mrs. L.* of the Junior League. *Hertz Company* has provided *Mrs. L.* with transportation to take J. R. over to *Dr. D.*'s house in northern New Jersey. That evening the *D.*'s and J. R. get acquainted.

On day 1, J. R. goes to school with the *D. children* for a half day. In the afternoon, since he has expressed an interest in law, he will be taken to lunch by a federal judge. *Judge H.* then allows the boy to sit in court for a couple of hours. Next, *Miss X*, a college student, arrives by *Yellow Cab* to take J. R. to see various *tourist landmarks* in New York City. A couple of his *new classmates* go on this trip. J. R. spends the evening with the *D.*'s, who extend themselves. He learns from *Dr. D.* that as a special treat on day 3 he is to visit *Gourdine, Inc.* to learn about an anti-air pollution method. Members of the *factory workers' union* will take him to the *Madison Square Garden* to see the *New York Knickerbockers*.

On day 2, J. R. goes to school where the class hears a report from *C. T.*, who has just returned from a CDE to the *Houston Space Center*. J. R. is asked to talk a few minutes about his own city. That afternoon *Mrs. Van M.*, a widow, arrives by *Red Cross* car to take J. R. to meet her husband's *law partner*. Here J. R. is shown the complete purpose and operation of a large corporate law firm. *Law clerks* agree to take him to a neighborhood law clinic during his stay. Later,

Mr. V., a Boy Scout master, takes J. R. and a group of boys for a ride in a *police squad car*. The boys are taken to a career-mobile which happens to be located in a Jewish neighborhood. The staff cadre has prepared an exhibit on ceramic physics with the help of *U.S. Gypsum*. The local *newspapers* and *TV stations*, as is their custom, have mentioned this exhibit in their regular coverage of the CDE. On this particular day there will be a *ceramic physicist* at the exhibit to answer relevant questions.

In another year, depending on the subcultural community's wishes concerning motivation and achievement, J. R. might win a trip to Latin America as a special award for community service work. The award money would come from *individuals* who made their "contributions" via cash instead of services. *Braniff Air Lines* will provide a seat and a *Peace Corpsman* will be J. R.'s host. After several days J. R. will return to the U. S. accompanied by a *State Department official*, who happened to be a classmate of the *businessman* who took J. R. to South America.

When J. R. is able to do so, perhaps at age 14, he will go on a CDE unaccompanied. He will stay at the *Sheraton Hotel* for one leg of the journey. Since *Greyhound Bus* is taking him to a second city, he will have the opportunity to stay at a *local seminary*.

CONCLUSION

Such a plan provides personalized attention and much individual attention to each participant. Staff and volunteers would have to have much contact with each volunteer and child before and during the actual trips. Those persons, agencies, or groups who couldn't participate directly could be solicited for

funds. Thus there is latitude to do what one wishes, from a minimum of sending in a few dollars all the way up to organizing a corporation or a federal department to initiate programs that would maximize exchange of experience. Organized brainstorming by individuals and institutions would logarithmically augment ideas about how the CDE could be made more effective.

Obviously there are drawbacks to the plan. Many rich and poor, black and white parents will be hesitant to trust a child to a stranger. Doubtlessly awful things can happen, such as rape of a teenage girl by a sponsor or the sudden illness of a child or his traveling companion. There will be Tom Sawyer-like mischief of a boy who loses himself in Chicago. Some children might be much discouraged or feel overwhelmed when they see how the other pole lives. Nevertheless, despite the magnitude of such consequences, the total plan need not be deterred or rejected. There is much more to gain in the balance.

For most children, adult volunteers, and staff it would be a positive experience in which everyone does what he can and whatever he contributes is a welcomed gain. The white would become more accustomed to grant respect to blacks and thereby help preserve his society and ensure new contributions to it. For the black it would show that the society cares and wishes him to succeed. Like the patient who is turned aside from suicide, the black would see that he can hope and that there are options that can resolve trapped feelings. Most important, it would demonstrate the attitude most essential in treatment of suicidal patients. Blacks would be shown that someone wishes them to live and that someone wants them to belong and to be accepted.

The CDE could be built so that no child could fail. For instance, if a ghetto neighborhood decided that children needed good grades it could allow a youth to win a trip he coveted if he secured all A's. However, as long as it judged that a youth tried, even if he got C's, he could be sent to a church day center with the chance to work x number of Saturdays in order to succeed in his wishes.

The CDE would also allow for special participation by selective employment groups such as senior citizens or vacationing college students. These special employees, among other things, would be directed to give help in situations where more one-to-one help was required, e.g. helping physically handicapped children on their trips.

In order to secure maximum benefit from these highly individualized exchanges, methods could be worked out so that each child would ordinarily be involved in a task-oriented group process during his trip. The tasks, of course, would have to be suited to the child's current stage of psychosexual development. A ship company might take a handful of boys of diverse sociocultural and economic backgrounds to work on board a ship going to Europe. The boys selected might have in common a desire to get in condition for the football season. They would be given such work as to assure their physical condition with the promise of a bonus of an extra paid day in Paris if they as a group achieved a certain quantity of work. Many short-term tasks, both useful and educative, which would be appropriate to the children under consideration could be found in any community during a school year.

Hopefully, the routinized acceptance

of sharing activities, homes, and friends would begin to have impact on the society. The dangers of homogenized communities, such as increased xenophobia, would be lessened. If the CDE worked it could be one step toward rupturing the cycle of violence-counterviolence both in the short and long runs.

The Children's Domestic Exchange offers each citizen, each government agency, each private institution an opportunity to be committed, concerned, and actively useful in applying a social remedy. At the same time, hope for peaceful and rewarding futures can become the property of all children, be they black, red, yellow, brown, or white. In time, therefore, racial attitudes could become more salutary.

When this is done, America can move on to other important issues. In the time it's taken for you to read this paper, five hundred people in the world have just died of starvation. While we considered the consequences of hate due to skin color, these five hundred people could have used the benefits from the compassion which may have accrued to them if our rich and generous country wasn't spinning wheels about the color of a neighbor's skin.

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THE MODERN AGE: A DILEMMA FOR PSYCHIATRY

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The objectifying techniques of our age have tended to promote an interpretation of the psychiatric symptom in terms of mechanism rather than meaning. To the extent to which psychiatric theory has fostered a view of man abstracted from the concreteness of his sociohistorical realities, it has unwittingly fostered the very conditions having potential for mental illness.

Psychoanalysis . . . the idea of a lie without a liar . . .

Sartre

It would appear that in our modern age, with its potential for devastating destruction based on unprecedented technological prowess, there is at long last the need to explode the myth of so-called impartial science. Knowledge is no longer neutral. The ethical ramifications of scientific research in the field of armaments of various sorts have recently been the subject of wide discussion and public indignation. The ethical ramifications of our quasi-medical mechanistic approach to the phenomena of mental illness, although not quite as

cataclysmic, nevertheless have pervasive consequences that shall be the subject of discussion in this paper.

More specifically I shall be concerned with an overall comparison between the mechanistic and humanistic dimensions of contemporary psychiatry. The latter focuses on conduct in terms of meaning and purpose, while the former explains conduct in terms of causes. At issue is the significance of these divergent strands within psychiatry in regard to its conception of man's potential for responsibility, freedom, and spontaneity. These moral considerations are not only basic to human conduct in general, they remain as crucial parameters in confronting the problem of mental illness itself.

Historically both European and American psychiatry have been characterized by a long-standing controversy as to the merits of a somatic—naturalistic—approach versus that of a psychological—moral—approach to the problems of insanity. The concept of insanity as an outgrowth of moral rather than physical aberrations was widely discussed as far back as the nineteenth century. The notion of moral insanity⁵ as an outcome of emotional lability gradually led to the concept of modern analytic psychiatry that tends to be at odds with the narrower somaticist approach. Nevertheless, in spite of the present-day popularity and influence exerted by the various schools of analytic psychology, the phenomena of mental illness continues to be a medical speciality presided over by the medical expert who is inclined to view such phenomena through a causalistic framework.

Why is it that in spite of the efforts of the analytic schools to provide a humanistic framework that would interpret the phenomena of mental illness in terms of meaning, motive, and purpose—concepts that as I shall indicate are antithetical to a mechanistic-causal approach to mental illness—it is the latter approach that continues to hold sway? It would seem to me that Tolstoy's perception helps to clarify a crucial aspect of this dilemma: "Not what we call science determines life but our conception of life determines what should be acknowledged as science."¹⁸ This view would imply that the contemporary predominance of the causalistic approach to mental illness rests not solely on the evidence of so-called pure scientific research and investigation; rather it is basically consistent with the mood and tenor of our sociohistorical era.

The persistent popularity of the medical mechanistic approach to mental illness is best understood when it is realized that this approach is fundamentally an outcome of as well as lending support to the technological demands of our time. A method of inquiry and investigation into the significance of mental illness (deviant conduct) consistent with a humanistic framework would necessitate an interpretation of such phenomena in terms of their relevance to our sociohistorical setting rather than one reducible to physicalistic explanation. The former approach has been largely ignored as a result of what Mills¹¹ has referred to as "methodological inhibition." The method of approach to a problem (mental illness) is thus determined not by its inherent requirements but rather by applying to it technological and physicalistic techniques that satisfy the demands of an era. Such inhibition leads to the inevitable transformation of man into a thing, as means become transformed into ends. It is consistent again with an age of technology that rests on a base of collectivism, impersonalization, functionalization—on man's alienation from himself.

HISTORICAL PERSPECTIVE

Foucault,⁷ in a little known but nevertheless masterly historical work, indicates that the quest to confront and grasp the meaning of madness, strangely enough, has receded to the background with the advent of the modern naturalist-physicalist approach that has placed its emphasis on either treatment or custodial care. "Classicism," he states, "felt a shame in the presence of the inhuman that the Renaissance has never experienced." And he adds: "Madness had become a thing to look at: no longer

a monster inside oneself but an animal with a strange mechanism." The mechanization of madness became synonymous with the loss of dialogue between madness and reason. Nevertheless, Foucault ironically implies, this dialogue lingered to the beginnings of the modern era in the form of the physical struggle that often ensued between patient and asylum keeper. The humaneness and kindness that later characterized mid-nineteenth century psychiatry, rather than fostering dialogue was at least in part a condescending paternalistic gesture. It was to this extent a means of discounting the mad as unworthy of serious contention.

Foucault implies that madness, when considered in all its seriousness and meaningfulness, may primarily be taken as a stance that embodies a criticism of the entire bourgeois work ethic. After all, "mentally ill" was the label affixed to those who possessed one singularly fundamental characteristic—a refusal to participate in society. In this light, modern-day psychoanalysis is not so much a discovery as an invention that clouds and obscures this humanistic protest by translating mental illness into instinctual-naturalistic language. Instinctual drives are thereupon viewed as mechanistic-abstract happenings without any relevance to the concrete social setting. This notion is inextricably linked to the demands of an era intent on "objectifying" man and which has eventually brought to an end the dialogue between madness and reason.

The language of instincts is further suggestive of a basic polarization between the individual and society. It presupposes that the former harbors within

himself anti-social urges that lie beyond his power of reason. At one and the same time he is suspect of evil-doing yet declared irresponsible. Man is viewed as conflict-ridden as a result of his instinctual endowment; he is at odds only with himself. The social order is thus invoked as necessary solely to tame man's instincts; human conduct tends to be viewed as automatic and thereby abstracted from the realities of man's sociohistorical situation.

DILEMMA OF PSYCHOANALYSIS * —HAPPENING OR MEANING?

The pervasive influence of the sociohistorical setting in which psychoanalysis has emerged has prompted a fundamental paradox that lies within the body of its theories. This dilemma revolves about the difficulties incurred in attempting to establish a degree of consistency within a theory of psychoanalysis that attempts to interpret symptoms in terms of both meaning and mechanistic causality at one and the same time. How is man to be simultaneously considered as a person and thing? How is humanism to be reconciled with mechanism? Meaning, it must be understood, depends on the purposes and motives of conduct engaged in by the spontaneous, subjective, individual. By contrast, causes refer to happenings that just "are" and therefore entail the postulation of neither meaning nor responsibility. This fundamental dichotomy has been expressed by Home¹⁰ as follows:

On the one hand in clinical practice, and especially through the technique of free association, it (psychoanalysis) assumes a spontaneous subject; on the other it reifies the concept

* In view of the obvious impact of psychoanalytic thought on contemporary psychiatric theory I believe that my remarks in regard to psychoanalysis are basically applicable to psychiatry as well.

of mind and elaborates a scientific type theory in terms of causes.

This schism embedded in the body of contemporary psychiatric knowledge becomes apparent as one further contrasts the theory and practice of psychoanalysis. The former is essentially devoted to mechanistic-naturalistic explanation; the latter to a psychological, humanistic interpretation of the meaning and purpose of human conduct.

With regard to theory, Freud⁸ himself has written:

It is the therapeutic technique alone that is purely psychological; the theory does not by any means fail to point out that neuroses have an organic basis—though it is true that it does not look for that basis in any pathological-anatomical changes, and provisionally substitutes the conception of organic functions for the chemical changes which we should expect to find but which we are at present unable to apprehend.

The implication is clear—psychoanalytic theory views the psyche as a reflection of the vicissitudes of biological instincts. In the same way that a camera lens apparatus refracts and projects light, the mind automatically reflects instinctual and libidinal drives. In other terms, psychoanalytic theory ascribes to the mind the automaticity and regularity that otherwise characterizes Newton's "billiard ball" universe. The mind has therefore been construed as analogous to a physical body.

By contrast, Freud's technique of psychoanalysis is nevertheless indicative of a marked concern for the spontaneity, subjectivity, and uniqueness of the individual. Psychoanalysis is, after all, a technique designed to liberate the patient whose freedom to act is compromised.

Psychiatric symptoms, as I shall mention, are in fact the means by which man, encouraged by his social setting, attempts to portray himself as if he were neither free nor responsible;¹⁶ in short, a victim of causes.

Freud's intuitive and implicit awareness of this very meaning of neurotic symptoms markedly influenced the form and technique* that would later characterize psychoanalytic practice. It is perhaps in this light that we may more readily understand the reasons for which Freud, early in his career, refrained from the use of techniques laden with authoritarian overtones such as hypnosis, physical examinations, and so forth. It became apparent to him that these techniques would only have furthered the patient's inclination to remain a distant, passive spectator. To persist in such techniques would have encouraged the patient's continued indulgence in the conviction that he was both helpless and irresponsible and thereby lend credence to the very impression that neurotic symptoms seek to establish and confirm. Other techniques and problems encountered in the practice of psychoanalysis, such as problems of countertransference and termination of therapy, may be viewed in a similar perspective. Freud was obviously determined that psychoanalysis develop into a technique that would maintain the highest regard for both patient accountability and spontaneity. The aim, therefore, of psychoanalysis as a technique is to facilitate action based on freedom and choice; it is not one of intimidation and subjugation that would simply have compounded the crisis for which the patient originally

* See Boss'⁴ work for an extensive appraisal and critique in regard to the dichotomy that exists between the theory and practice of psychoanalysis.

sought psychoanalytic assistance. It is this strand of psychoanalysis that must be pursued in greater depth.

The humanistic therapist who must be aware of the unfortunate ethical ramifications that stem from the logical inconsistency inherent in contemporary psychoanalysis must choose to reinterpret some of its most classical findings and conclusions. In this regard Fromm has translated Freud's Oedipus complex⁹ from the naturalistic language of instinct into the everyday human terms of power, coercion, and intimidation. He suggests that the essential meaning of the Oedipus complex lies neither in the issue of sexual instinct nor rivalry but pertains to the power struggle between parent and child.

In these terms the Oedipus fixation would refer to the fact that freedom, spontaneity, and responsibility are relinquished in an effort to placate and appease oppressive forces, both past and contemporary. Neurotic strategy and tactics based on such retreat commences in childhood and may be continued in the same pattern throughout the individual's life. The individual who has encountered and lived within oppressive, intimidating situations will be disposed to forfeit his potential to act responsibly in view of his ceaseless and unending anticipation of defeat of both his hopes and aspirations. It is from this perspective that the significance of Oedipus material, i.e. fantasied or actual preoccupation with incestuous-genital gratification, must be reinterpreted. Oedipal preoccupation rather than the cause *per se* of neurosis becomes the means by which the neurotic individual distracts¹⁰ himself from the demands and responsibilities that life places upon him.

In so far as its ethical content and ramifications are concerned how may we

compare the humanistic element with the classical theoretical framework of psychoanalysis? The latter's theoretical formulations suggest that man is primarily preoccupied with intrapsychic conflicts that reflect biological instinctual drives. Such a physicalistic viewpoint conceptualizes man's conduct in an abstract universal sense, divorced and apart from the totality and reality of the immediate concrete sociohistorical condition. Furthermore, it conveys the impression that human conduct is inherently naturalistic, automatic, and predictable. The potential for spontaneity and responsible purposeful action is thereby viewed with reservation.

The humanistic framework, on the other hand, relies more exclusively on the ordinary language of power, freedom, and responsibility than on the physicalistic disease "cause-effect" model of human behavior. It undoubtedly points more emphatically to the everyday social and political forces that mold human conduct. Yet one may say that neurotic conduct is not at all ordinary but is characterized by a heightened emotional display of irrational conduct, amongst other features. It is not to be assumed that such conduct is a simple product of naturalistic instinctual endowment; rather it must be understood within the entire context of the particular human situation. If in an alienating world man is often engaged in an escape from freedom, spontaneity, and responsibility, instinctual or emotional behavior is not the cause but one of the many means toward this end.

EMOTIONS, AFFECT, AND INSTINCTS —CAUSE OR CONSEQUENCE?

The principal contemporary psychiatric conception of mental illness is

that it is caused by the presence of repressed or aberrant emotions, affect, and instincts. I submit that this contention has severely undermined the notion of individual responsibility and volition for the following reasons: First, such a theory is both an outcome and a support of a cause-effect model of human behavior wherein repressed affect, as an instance, leads to mental pathology, aberrant conduct, etc. A theory steeped in terms of causality accounts for human action basically in mechanistic terms that are beyond individual control and isolated from the context of the human situation that rests on a base of creative purpose and meaning. The notion of causality is therefore antithetical to the exigencies of the human situation that revolve about the elements of spontaneity and subjectivity. Secondly, man is viewed as one who is naturally endowed with anti-social, irrational, brutish emotions that tend to undermine his potential for responsible action. Thirdly, emotions are considered to be essentially intangible, ephemeral, and somewhat mysterious phenomena that operate beyond the limits of responsibility and reason.

How are we then to reinterpret the phenomena of emotions and affects in a way that is consistent with a humanistic framework that takes into full consideration the dimension of spontaneity, responsibility, and purpose. We must suggest that what has been understood as an explanation of human action in fact needs further explanation itself. The expression of emotion and impulsivity are not in themselves causal naturalistic happenings that operate beyond the control of the patient. Rather, further inquiry into their meanings, uses, and consequences reveal them to be an

indication of man's very ability to respond to anticipated danger and failure by acting as if he were passive, irresponsible, and helpless; in short, as if he were a thing. It is the patient's guilt, depression, fearfulness, and anger that he at one and the same time both creates and seizes upon in an effort to persist in his role of passivity and irresponsibility. It is therefore neither the constellation nor intensity of emotions that cause mental illness; to the contrary, these very emotions are the expression, manifestation, and consequence of the human condition that prompts man to abdicate from responsible, reasonable action.

It was Adler who perhaps first insisted that the emotions and instincts which Freud took to be "cause" were in fact "consequence" and thereby provided a forceful impetus to the humanistic strand of psychiatry. As such, heightened emotions, feelings, impulses, and instincts are artifacts created by the individual to provide for himself the necessary distractions so that he can continue to maintain his life plan geared towards retreat and withdrawal from the demands of existence. Adler wrote:

The affects are not mysterious phenomena which defy interpretation; they occur whenever they are appropriate to the given style of life and the predetermined behavior pattern of the individual. Their purpose is to modify the situation of the individual in whom they occur, to his benefit. They are the accentuated, more vehement movements which occur in the individual who has foregone other mechanisms for achieving his purpose or has lost faith in any other possibilities of obtaining his goal.¹

In short, neurosis "is a creative act and not a reversion to infantile atavistic forms."² This conceptualization of emotion and instinct in terms consistent with a concept of originality and spon-

taneity is basic to the humanistic tradition in which man is seen as a creator rather than creature.

Sartre¹² in his phenomenological analysis of the problem of emotion lends support to these basic humanistic contentions. He states:

... emotional behavior is not a disorder at all. It is an organized system of means aiming at an end. And this system is called upon to mask, substitute for, and reject behavior that one cannot or does not want to maintain.

Further, he comments in regard to a specific emotion:

... sadness aims at eliminating the obligation to seek new ways, lacking the power and will to accomplish the act which he had been planning we behave in such a way that the universe no longer requires anything of us.

Emotions, affect, and feelings therefore are neither inborn naturalistic phenomena that lie beyond the realm of human meaning and volition nor are they instrumental in the causation of mental pathology. To the contrary, they must be interpreted as meaningful, purposeful creations (as are all other symptoms) designed to facilitate one's retreat from obligations and responsibility.

Such retreat may be manifest either by violent impulsive behavior or by passivity and inertia. Within the traditional contemporary psychiatric framework both these modes of conduct are considered in causal terms: as a product of either natural endowment or intrapsychic forces within the individual or group involved.* Such a mechanistic interpretation of human conduct serves

only to heighten the isolation and powerlessness that has provided the initial impetus to such conduct and insult is thereby unfortunately added to injury.

THE UNCONSCIOUS: MEANS OR END?

It is clear that within the framework of contemporary psychiatry the concept of emotion and affect is utilized at least in part in support of a causalistic theory of neurosis. At this point it would be useful to examine the relationship that exists between the classical psychoanalytic theory of the unconscious and what I have referred to as a mechanistic-naturalistic explanation of neurotic conduct. If one were to take the Freudian psychoanalytic framework literally, the unconscious would be tantamount to a niche or recess into which are repressed the various traumatic emotions, affect, impulses, and instincts. In his well-known metaphor of the "iceberg," Freud suggests that it is from this hidden recess that affect and impulses exert their ominous causal role in human conduct. The patient is thereby conceptualized as a hapless victim of complex "unconscious instinctual" forces operating beyond both his grasp and understanding. Man becomes a passive host whose psyche serves as a battleground for the conflicting forces of the id and superego. The principal impression conveyed is that the outcome of this conflict is beyond the influence of the individual and as such he is basically powerless to determine his proper mode of conduct.

In so far as traditional psychiatric theory is concerned, the interpretation

* See Fanon's⁶ outstanding sociohistorical analysis regarding alternating episodes of violence and passive conduct in the Algerian native. According to Fanon the source of such conduct is not at all biological or intrapsychic but is to be interpreted on the basis of the oppressive coercive social setting. I have elsewhere¹⁴ hypothesized that neurotic or irrational conduct may be correlated with social circumstances.

of symptoms or conduct in terms of meaning and purpose presented by the responsible spontaneous subject is clearly minimized in favor of explanations based on unconscious internal instinctual derivatives reducible to unalterable physical dimensions. Phenomena delegated as natural and unalterable presuppose neither meaning nor purpose. The unconscious in this vein becomes a fixed end; as a result, human conduct is portrayed as both involuntary and inevitable. On an individual plane this signifies that the virtues of a morality of risk and freedom are obviated in favor of one based on predictability and certainty. With such a morality there is the forfeiture of individual option and inclination. On a social plane it tends to divorce the meaning of individual action from the fabric of the society in which it occurs.

In contrast to the mechanical Freudian concept of the unconscious with its naturalistic overtones, a humanistic framework requires a man-centered theory of the unconscious based exclusively on purpose and meaning—a theory in accord with a belief in man's potential to create and strive toward goals rather than be driven solely by mechanistic causes. It is this that perhaps Adler had in mind when he wrote:

What might otherwise be regarded as the termination, namely the specific disease, now takes its proper place as a means, a method of life, a symptom indicative of the past taken by the patient to attain his goal of superiority.²

A humanistic theory of the unconscious similarly cannot serve as a basis for explanation in terms of mechanistic antecedent causality but rather serves as an investigative tool to scrutinize

motives, purposes, and meaning of an individual's goal. The unconscious is therefore not a "region" into which affects are repressed; rather it is simply a matter of what is unknown or "not understood." Actions that are "not understood" become all the more useful as tactics or means (as any other symptom) in the quest of particular ends.

The various scientific theories of the unconscious are living proof of what was suggested earlier. Knowledge is not at all neutral. In spite of the benevolent intention of their exponents, theories of the unconscious have had their unfortunate ethical ramifications. Notions of the unconscious have given support to a general aura of mistrust and suspicion that is characteristic of both individual and mass psychologies. The mistrust and suspicion that is manifest today between man and man, nation and nation has undoubtedly found much justification in the psychological theory of the unconscious. The deed and word of the other is always suspect; ulterior motives and deceit are always to be anticipated. It would seem that the Freudian theory of the unconscious is particularly somber and pessimistic in that it links duplicity and deception to man's unalterable biological nature. The hypocrisy of man becomes his destiny. In any case, knowledge of analytic theories of the unconscious have all too often been turned to the advantage of ill will and egoism; responsible conduct and dialogue have been all too often successfully undermined.

CONCLUSION

It has been said that man is both creature and creator. The former dimension of man has preoccupied much

of contemporary psychiatric work and thought. Therein man has been conceptualized as one who *is* a body; the psyche is represented as a facsimile of a bodily organ whose functioning depends on the vicissitudes of inborn biological and instinctual drives. Man's conduct is therefore construed as an outcome of natural phenomena abstracted from his sociohistorical setting.

The dimension of man as a creator—one who is spontaneous and responsible—must yet be given its due consideration. Man is one who *has* a body. It is the meaning, motives, and purposes of his bodily actions that must be scrutinized. Neurotic conduct need not be explained in mechanistic terms; what appears to be irresponsible conduct may now be viewed as a creative though often unfruitful solution to the demands of life. The task of a humanistic psychiatry ought to be that of translating from the language of abstract universal instincts anchored within a naturalistic framework to a language in which man's conduct signifies response to or perhaps question of the demands of existence within his particular sociohistorical setting.

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NEURONAL PLASTICITY AND MEMORY

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All of the somatic therapies useful in psychiatry modify synaptic membrane activity. Future investigations may discover means by which pathways can be selectively activated or deactivated, not only by learning but with the aid of chemical interventions. This review outlines a chemical-functional model which may become possible as a basis for modification of behavior.

I. HISTORICAL BACKGROUND—GENETICS AND BEHAVIOR

Memory seems so uniquely associated with life that it has been invoked to account for the most diverse of biological phenomena. For Lamarck it was the driving force behind evolution; for the immunologist it contained the secret of the anamnestic reaction; for the embryologist it was the rationale behind the determination of cell lines. In recent times the poetic phrase "genetic memory" has come into vogue, though with a very different meaning from that which Lamarck might have attributed to it. Yet, the biology of memory has developed at a frustratingly slow pace. At this writing virtually nothing is known with certainty except that which has been common knowledge through the ages—animals can and do make a record of their personal experience.

Memory is, no doubt, a complex phenomenon; but, its probable complexity can only in part account for our ignorance of its biology. More important has been the rejection of memory as a relevant variable in genetics, evolution, physiology and biochemistry. From Claude Bernard to Watson and Crick, from homeostasis to the double helix, biology has advanced by searching for the universal constants which underly the bewildering complexity of its world. Patterning itself after physics, biology sought that which is invariant and ubiquitous, that which serves the conservation of the living process through the generations and throughout the phyla.

The biology of change, of variation, of adaptive response, the dominant themes in Lamarck and Darwin, became the

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leitmotif of the new biology. Only when evolution was explicated as an accident, a random change in an inherently stable and invariant system, was a bridge built between the rigid laws of Mendel and the luxurious variety of life on the planet. Ontogeny became rational when the old idea of the homunculus was given a modern dress, an unfolding of a preprogrammed set of genetic directions already present in the fertilized egg. Homeostasis was revealed as the principle mode of existence of the mature cell, resisting most environmental pressures for modification with the aid of its numerous "allosteric enzymes,"⁴⁰ the internal governors and protectors of the constancy of the *milieu intérieur*. The immune reaction has become a microcosm of evolution itself, with antigens (the environment) selecting out and stimulating the activity of preexisting clones of cells which have the ability to react with them.¹⁰

Brilliant illuminations derived from the dedication to constancy. Invariant DNA permitted biology to distinguish the main outlines, if not all the details, of those processes which determine the genetic continuity and the functional integrity of the cell. With these successes, the theory that individual experience is the directing force behind biological organization lost its lure; memory became an epiphenomenon whose study was to be postponed until the fundamentals of biology were well in hand.

Insofar as psychology is a part of biology, its theoretical structure was built with little reference to memory. For Freud, drives are inherent and unlearned and somehow related to homeostasis for their expression. The energy which gives them force is but a specific instance of the universally valid generalization of

physics, the first law of thermodynamics. Two Hegelian antagonists, the instincts of life and death, perform an endless and repetitious *pas de deux* whose choreography, written eons ago, is the true dance of life. The secondary role played by memory in Freudian theory is emphasized by the following quotations from *A General Introduction to Psychoanalysis*²¹:

Let us suppose . . . that every mental process . . . first exists in an unconscious state or phase, and only develops out of this into a conscious phase, much as a photograph is first a negative and then becomes a picture through the printing of the positive. But not every negative is made into a positive, and it is just as little necessary that every unconscious mental process should convert itself into a conscious one. It may be best expressed as follows: Each single process belongs in the first place to the unconscious psychical system; from this system it can under certain conditions proceed further into the conscious system.

Or:

The why of the symptom, its tendency, is however always an endopsychic process, which may possibly have been conscious at first, but just as possibly may never have been conscious and may have remained in the unconscious from its inception.

Contemporary theorists express notions which are not dissimilar:

The primitive attitude of the organism toward the environment lies within the organism itself, and this is conditioned by sensory input. Actions emitted by the organism are goal-directed, and the goals are internal satisfactions. These satisfactions need not be consciously experienced, nor the behavior consciously directed.³⁶

For Lorenz³⁷ learning is an environmental trigger for the activation of a behavioral pattern lying coiled within the DNA; and he is well within his scientific rights to appeal to the DNA theory of memory for support.

Studies of the reticular formation lend

credence to the contention that the ultimate revelations about behavior are to be found in genetics. In 1954 Delgado, Roberts, and Miller¹⁸ discovered that direct stimulation of the brain could be employed to teach animals avoidance behavior. Later work has given Delgado the power to turn aggressive behavior on and off by simply activating judiciously placed electrodes in the reticular formation. In the same year Olds and Milner⁴⁴ found that other electrode placements (again in the reticular formation) could be used to teach approach behavior. Such animals engage in repetitive stimulation of their brain sometimes in preference to behavior that would

permit them to satisfy hunger, thirst, or sexual "drives." These behaviors seem comparable to an automaton programed to zero onto certain physical parameters, not to the behavior of an "intelligent" organism with a conscious choice. Memory and experience are preempted and behavior is laid bare as a mechanism functioning to produce certain "states" in the reticular formation. Evolution had selected out those forms whose preservative life activities provide the reticular formation with "satisfactions" and in whom potential dangers act to stimulate the "dissatisfaction" centers of this primitive portion of the brain. DNA and Darwin, Darwin and DNA.

II. NEUROPHYSIOLOGY AND BEHAVIOR—WHERE DOES GENETICS END?

Yet the environment does teach and its lessons are attested to by our individual and unique memories and by the growth of directed and purposeful behavior during the maturation of the individual organism. Some biologists persisted in the study of this process, even after its forced abdication as the prime mover of biological theory.

Pavlov⁴⁶ began the experimental analysis of the links between learning and the biological substratum. He showed that through experience a relation between environmental events and the preexisting behavioral repertory could be established. The unconditioned reflex (for example, the salivation evoked by mastication) could become associated through experience with almost any environmental event which was coincident with the appearance of food. It should be emphasized that Pavlov's rationale included the presence of preexisting, unlearned behaviors, behaviors that were part of the genetic endowment of the particular species under examination.

Learning, then, was the process through which neuronal associations were established between the cerebral hemispheres (that part of the nervous system which was conscious of the environment) and the other parts of the brain which regulate behavior without consciousness and without the requirements of experiential activation. Memory was the proof that these links had been established.

Does the brain limit neuronal associations to the development of responses that are appropriate for purposeful behaviors? Pavlov showed that the presentation of contradictory environmental signals produced an animal that was incapable of directed behavior. His "neurotic" dogs retired to a corner of the cage manifesting their inability to cope with the contradictory environment by a refusal to act, even when subjected to continuous noxious stimuli.

Ukhtomsky⁶⁰ and his students conducted a long series of experiments dating from the middle twenties which complicated this analysis. They discov-

ered that, after repeated strong stimulation of a reflex receptive field effecting limb extension in the spinal frog, a stimulus to the receptive field of flexion resulted, not in flexion but in a marked reflex extension. In later work, Rusinov⁵³ examined the effects of anodal polarization of the motor cortex on reflex activity. Following anodal polarization of the cortex, a weak peripheral stimulus, previously incapable of inducing a motor response, was now effective. The response, however, was characteristic of the area of the motor cortex that had been subjected to polarization not to the receptive field of the reflex which was stimulated. These results, dubbed the "dominant focus," opened new dimensions for theory. The animals were not making a "goal-oriented" response, nor were they manifesting a preordained organization of behavior which might be expected if the anatomical organization of the nervous system limited the relations between input and response. Apparently, virtually any neuronal association was possible; all that seemed to be required was the simultaneous stimulation of any two neuronal complexes.

Pavlov's belief that intact cerebral hemispheres were required for the development of the conditioned response was complicated by Sherrington's⁵⁵ work on spinal reflexes and Ukhtomsky's⁶⁰ on the spinal frog. The work of DiGiorgio¹⁶ and her associates raised additional questions. Her work suggested that learning and memory may be widely distributed in the nervous system. Marked postural asymmetries were produced in animals by unilateral cerebellar lesions. If the spinal cord was transected immediately after producing the cerebellar lesion, the animals resumed a normal posture. However, if some 40

minutes were allowed to elapse before the spinal cord was transected, the postural asymmetry disappeared temporarily only to return to a somewhat lesser degree but in a long-lasting form. These experiments were repeated on decerebrate animals, demonstrating their independence of the cerebral cortex; and further, by deafferenting the forelimbs, it was shown that the persistent asymmetries were independent of peripheral feedback that might be under the control of a spinal pathway. It would seem that even the peripheral nervous system can be "taught" and can "remember."

Morrell⁴² has described a comparable phenomenon in the central nervous system. He established an epileptic focus in one cerebral hemisphere by implanting alumina gel. After a time he could record aberrant electrical activity in the corresponding locus of the contralateral hemisphere which occurred in synchrony with the spike discharges emanating from the original epileptic focus. If the original focus of aberrant electrical activity was ablated quickly, the contralateral hemisphere returned to normal. However, if a certain period of time was allowed to elapse (several days in the rabbit, 4-12 weeks in the cat, 8 weeks or more in the monkey) before the ablation of pathological tissue, the contralateral focus of electrical abnormality persisted. Histological examination of the "mirror" focus revealed high concentrations of RNA.

These experiments recall the proposals advanced by Tanzi⁵⁹ in 1893 and by Ramon y Cajal⁴⁰ in 1909. They suggested that learning and memory are manifestations of subtle structural changes at the synapse caused by use and resulting in increased synaptic efficacy. Eccles,¹⁷ a modern proponent of this view, expresses it as follows:

We may assume that a given sensory input results in a uniquely patterned activation of central neurons; and . . . a subsequent representation of the input would tend to be channeled along the same pathways because of the increased efficacy of the synaptic action exerted by all these neurons activated initially. There would thus be a further reinforcement of the synapses responsible for the unique pattern of activation and response, with consequently a more effective channeling; and so on, cumulatively, for each successive application of that sensory input. Necessarily, the postulated changes in synaptic efficacy must be of very long duration—days or weeks.

Ingenious experiments have been devised to test this theory. Wiesel and Hubel⁶⁴ raised cats with either one or both eyes sutured closed from birth. The deprived eye or eyes proved to be blind after three months and atrophic changes were observed in the lateral geniculate bodies. In the case of single eye sutures, the ocular dominance of many cells in the striate cortex was modified, resulting in a preponderance of cells showing either contralateral or ipsilateral dominance. This result contrasts with the normal animal in which the majority of cells receive input from both eyes. With bilateral closure, even though many gross abnormalities were discerned, a great proportion of the cells again show bilateral responsiveness. These results cannot be interpreted in terms of a simple use and disuse model. Apparently factors relating to the interactions between the pathways leading from both eyes determine the properties of many cells.

Examination of the effects of tetanic stimulation of homosynaptic pathways⁶⁸ raises other problems. In these experiments, a brief tetanic stimulation ("priming" stimulus) is followed by a sharply augmented (or depressed) response to frequently repeated non-tetanic stimuli. The altered response persists for

several hours. Has the system "learned" a new response under the tutelage of the tetanizing impulses which it slowly "forgets" when these are no longer present? Or are the frequently repeated non-tetanic stimuli also "educating"? Do they impose a "new" pattern of response just as did the "priming" stimulus? Or does the original tetanizing impulse produce a temporary chemical or structural anomaly which is slowly repaired? These questions are not only pertinent to the understanding of post-tetanic potentiation but may be related to the nature of memory. Are memories a change in some neuronal element or aggregate which depends upon continuing activation for their persistence or do they persist until the neuronal aggregate is taught a new response?

A similar question is raised by the results obtained with simplified models of the Pavlovian conditioned reflex. Kandel and Taub⁸¹ studied the effects of nerve stimulation at different frequencies on excitatory postsynaptic potentials (EPSP) in the isolated abdominal ganglion of the mollusc *Aplysia depilans*:

The stimulus parameters to two afferent nerves were selected so that the test stimulus produced an EPSP and the priming stimulus produced a burst of spikes. The two stimuli were repeatedly paired once every 10 sec with the test stimulus preceding the priming stimulus by 200–300 msec.

In most of the cells examined, input pairing produced no facilitation of the test EPSP. However, in the right upper quadrant giant cells and in some unidentified cells located near the medial borders of the giant cells, the test EPSP was augmented during pairing; facilitation declined slowly (up to 40 min) after the pairing procedure.

Space does not permit a more detailed review of the variety of evidence pointing to conditioning and habituation in intact and simplified preparations. The

recent review by Kandel and Spencer³² is recommended and includes a thorough and critical evaluation of the physiological investigations into neuronal plasticity.

In summary, neuronal plasticity is a real phenomenon; it is a widespread

and general property of the neuron, going beyond the limitations that Pavlov thought were present; changes in response are intimately associated with use; and, finally, genetic determination may play a somewhat lesser role than had been believed.

III. THE BIOCHEMISTRY OF NEURONAL PLASTICITY

MOLECULAR MEMORY CODES

—GENETICS AGAIN

Biochemistry has contributed little to the understanding of neuronal plasticity, despite the popular impression to the contrary. It is highly dubious that a successful chemical transfer of memory has been accomplished.²⁸ Dramatic changes in the quantity and quality of brain RNA of animals subjected to intensive training²⁸ is poorly understood and may have no direct relationship to memory. Inhibitors of protein synthesis which disrupt memory^{1, 5, 20} exert these effects only when more than 90% of the total protein synthetic activity of brain is abolished—hardly a demonstration of the specific function of protein in either the formation or retention of memory. Chemicals which stimulate memory are active in some laboratories and not in others,^{19, 57} a property they share with injected RNA and protein.

Nevertheless, the interest in the possible role of RNA in memory has made a useful contribution to the neurosciences. It has forced a confrontation of at least one issue—the definition of memory.

The term “genetic memory” was originally coined in a perfectly innocent way. All that was intended was a loud blast upon the triumphal trumpet, a dramatic advertisement of a truly significant scientific discovery—the molecular

mechanisms underlying Mendelian genetics were now understood. So defined, “genetic memory” is the antithesis of the memory which is a record of individual experience; a record which can be as different in identical twins as between any two individuals chosen at random.

But even the most worthy advertising campaigns have their dangers. Ardent captives of Miss Molecular Biology's Madison Avenue image stormed the door of the beautiful and self-sufficient young debutante. Little expense or effort was spared in laying at her feet the most dazzling of gifts. By far the most striking were the correlation between memory and RNA changes in brain, and, that most ingenious of all pedagogic innovations, a classroom whose essential equipment was a hypodermic syringe containing the accumulated knowledge of the centuries. Yet she hesitated. For, she reasoned, if RNA, protein, or both are crucial to genetic and individual memory, it is logical to conclude that some essential difference between the two is not yet known. For she knew her family tree well. In the living organism, RNA is never made except from a template which dictates the most detailed elements of its structure. In animals, the dictator was always DNA, a molecule she believed to be invariant in each cell from the moment of conception to the moment of death. Furthermore, that part

of her personality which excited the most interest, her "messenger RNA," was, behind all of the glamour, simply that, an intermediary in transmitting to the protein synthetic system the detailed instructions dictated by DNA so these could be translated into the language of protein. Thus, each protein presumed a unique messenger RNA which in turn presumed a unique segment in the master molecule, DNA—in two words "genetic memory." Molecular code memory theories must then either attribute the pre-existence of individual experience to DNA, remarkable prescience, especially in the one cell state; or, it must assume that these products of DNA are merely the precursors of a code which is formed by some other, as yet undefined, process. The first proposition seemed to her ridiculous on its face. The second merely reaffirmed her initial concern that the mere involvement of RNA and protein in memory was an insufficient basis for a stable and productive marriage to neurochemistry.

The pressures to betroth individual and genetic memory, however, were not so easily dismissed. The ethological branch of the family insisted that the marriage would be fertile. According to their supplications, at least some behavior is instinctive. This behavior is not learned but appears spontaneously in the presence of some appropriate environmental or hormonal stimulus (or perhaps an appropriate confluence of these). While the activity so generated is totally novel to the individual, it is identical in all important details to the behavior that is manifest by other individuals of this species given the same circumstances. Hyden²⁹ describes one instance of what he calls "memory on the first level." "The capricorn beetle larva,

for example, makes a chamber twice as big as itself to fit the beetle which does not yet exist." The equation of behavior and "memory" seems at first sight plausible. The activity of the beetle involves a complex integration of neuronal pathways and an apparently "planned" result. Nor does this behavior occur at random, but only when appropriate and on signal.

But it can be argued that if this behavior is totally determined by the genetic apparatus, if in fact it is instinctive in the sense defined above, it is not memory. That complex nervous integrations are required for its expression is no more relevant than the complex nervous activity which accompanies normal growth and development *in utero*. The "fore-ordained or directed" result, achieved without previous experience or training, is no more relevant for a theory of memory than is the fact that an appropriate stimulus can elicit an arm, a leg, a liver, or even a nervous system during morphogenesis.

This attempt to demonstrate the equivalence of instinct and memory is an old idea, dating from Lamarck and defended with skill by Samuel Butler.¹¹ In his *Life and Habit* he writes:

It would also appear as a general principle—that unconscious knowledge and unconscious volition are never acquired otherwise than as the result of experience, familiarity, or habit; so that whenever we observe a person able to do any complicated action unconsciously, we may assume both that he must have done it very often before he could acquire so great proficiency, and also that there must have been a time when he did not know how to do it at all.

Whenever, therefore we see any creature able to go through any complicated and difficult process with little or no effort—whether it be a bird building her nest, or a hen's egg making itself into a chicken, or an ovum turning itself into a baby—we may conclude

that the creature has done the same thing on a very great number of past occasions.

We found the phenomena exhibited by heredity to be so like those of memory, and to be so utterly inexplicable on any other supposition, that it was easier to suppose them due to memory in spite of the fact that we cannot remember having recollected, than to believe that because we cannot so remember, therefore the phenomena cannot be due to memory.

We therefore assumed that the phenomena of heredity, whether as regards instinct or structure were mainly due to memory of past experiences, accumulated and fused till they had become automatic, or quasi automatic, much in the same way as after a long life. . . . "Old experience do attain to something like prophetic strain."

She knew that this beautiful song had seduced her ancestors. She found it easy to close her ears when it was sung again.

MEMBRANES AND THEIR ASSEMBLY—A SECONDARY ROLE FOR THE NUCLEUS

Neuronal plasticity can be studied without theoretical preconceptions, even by biochemists. For example, it is likely that the examination of the plasma membrane will yield relevant information. The plasma membrane is the only portion of the cell in direct contact with the environment. It is plausible, therefore, that environmentally imposed changes in cellular metabolism will be initiated at this site. Further, a specialized kind of plasma membrane, the synaptic membrane, directs many of the specialized functions of the neuron. Neurohumours are concentrated near the presynaptic membrane and upon appropriate stimuli, they move through it. At least some of the hormone is captured

by the postsynaptic membrane which undergoes massive changes in state as a consequence of this new extracellular environment. Ions begin to flow through the membrane carrying electrical charges which either stimulate the discharge of the postsynaptic cell (excitation) or freeze it in a nondischarge state (inhibition). Nor do these exhaust the events which occur at the synaptic membrane. Enzymes which either destroy or remove the neurohumour, thus terminating its effects, are located here. Whatever the mechanisms underlying neuronal plasticity, they are likely to be expressed in a change in one or more of these processes.

Enzymes are often part of structure and the plasma membrane is no exception. Some have been mentioned which are associated with the synaptic membrane but all cells contain enzymes that direct incoming and outgoing metabolic traffic. Recently, an appreciation of the profound changes that take place in the plasma membrane in response to a changing extracellular environment has developed. When the plasma membrane of a liver cell comes into contact with adrenalin, adenyl cyclase, a relatively quiescent enzyme localized in this structure, comes to life. Suddenly, ATP* (a metabolic energy source) which is usually converted to ADP† or AMP** is converted in part to cyclo-AMP.†† This derivative produces a variety of changes in cellular metabolism, the notable one in this case being the stimulation of glycogen breakdown.⁵¹ An exhaustive account of similar hormonally induced membrane changes would constitute a major review. Here it is only

* ATP=adenosine triphosphate (an energy source).

† ADP=adenosine diphosphate (sometimes can produce energy for metabolism).

** AMP=adenosine monophosphate (cannot be utilized for energy).

†† Cyclo-AMP=3', 5'-cyclo-adenosine monophosphate (a high energy derivative of AMP).

important to mention that many, if not all, hormones produce "plastic" changes in cellular metabolism, i.e. changes which cause a qualitative reorganization of the metabolism of the cell.

These activities are crucial to the role of the plasma membrane as the *Konzertmeister* of the cell, but there is nothing in the above which defines a new set of biochemical principles. The cell membrane appears to be a specially adapted organelle for the temporary modification of cellular metabolism in response to specific changes that occur in its environment. Presumably, in order to carry out these special functions, it has been endowed by nuclear DNA with a unique complement of enzymes which are "programmed" for sensitivity to special signals. Further, this kind of plasticity has no past. The reorganization of cellular metabolism is followed by the previously existing metabolic state without an apparent trace of its intervening experience. Plasticity—yes; memory—no.

But in the jargon of the computer age, the cell membrane may contain more "information" than that which permits it to react with this or that hormone. Membranous structures in the amphibian egg may direct differentiation.¹³ Individuals who develop from eggs with a damaged "grey crescent," a portion of the plasma membrane without either RNA or DNA, produce eggs with defective "grey crescents." Grafting experiments show that this region determines the formation of the dorsal lip and initiates the morphogenesis of the nervous system. Siekevitz,⁵⁶ on the basis of very different studies, has suggested that cell membranes cannot develop without prior membranous elements. These he calls the "ur-membrane."

Are cell membranes then self-replicating? Certainly not in the sense that they are a self-contained reduplicating system. An intact metabolic machinery is required for their production. Since protein constitutes a part of all membranes, the DNA-RNA-protein story must somehow be involved. However, can membranes select available molecules according to a sequence which is determined by the existing organization of the membrane itself? If membranes have this ability, the forces which determine membrane structure would lie in the membrane, just as the forces which determine crystal growth lie in the crystal. Clearly, this is a kind of self-replicating system, though a much more primitive one than that which guarantees the replication of DNA.

Much that is known about the properties and formation of membranes is consistent with this proposal. Membranes have a complex structure, being composed of protein, phospholipid and polysaccharide. Yet membranes are formed and destroyed at a very high rate.⁵⁶ One of two methods could have evolved to support this rapid membrane turnover. One, a kind of repair system by which individual molecules could be replaced on demand, no matter what their place within the membrane. The other, the synthesis of wholly formed membrane units to replace old and damaged membrane, might be likened to an assembly line in which component parts of the membrane are put together and extruded in a continuous ribbon of identical composition.

The forces which determine membrane assembly could exist either in some master system outside of the membrane, or they might lie within the membrane itself. In the latter case, it

would be the membrane which is directing its own replication though it certainly employs precursor materials formed by other systems within the cell. The persistence of characteristic membranes in the grey crescent of the amphibian egg from one generation to the next;¹³ the evidence for an "ur-membrane";⁵⁶ and, the ability of membrane assembly to continue for a time after protein biosynthesis is almost completely inhibited⁵⁰ are all more easily encompassed into a self-organizing model than into one which presumes a separate, DNA-regulated mechanism for the assembly of cell membranes.

SYNAPTIC NUTRITION —IS DNA THE MASTER OR THE SLAVE?

Relevant to these speculations are studies of the biosynthesis of synaptic membranes. A group of related phenomena have been uncovered which point to a heretofore unsuspected mechanism of adaptation and change. It will be argued that this mechanism, though representing less than 2% of the total protein synthetic activity of the neuron, permits the organism to write its personal history.

Weiss⁶³ showed that a continuous flow of protoplasmic elements from the perikaryon towards the periphery occurs at a slow rate (some few millimeters/day). He concluded that this process provides remote portions of the neuron with the macromolecules it requires for its integrity. His concept was supported by *in vivo* experiments which indicate that the synaptic areas contain no *in situ* protein synthetic activity.^{4, 18, 45} If radioactive amino acids are injected into the brain and the protein which is

synthesized from them is examined, its exclusive early localization is in the perikaryon. After a time, radioactivity can be recovered from the synaptic region. The result is consistent with Weiss' accounts of somato-axonal flow, since the time required for the appearance of synaptic radioactivity is roughly equivalent to that which might be expected if all protein is formed in the cell body and then moves toward the synapse at a slow rate. It also bolsters the argument that, if synaptic modification is involved in neuronal plasticity, and if this modification depends upon protein synthesis, it is the nucleus of the cell, its DNA, which is crucial for the coding of these proteins.

These experiments also provided a chemical rationale for the evidence that memory is dichotomized into two different processes; the one, short-term, which comes into play almost immediately (the memory which links one moment to the next) and is very sensitive to insults, being disrupted by electric shock and trauma; the second, long-term, which is established slowly but, once established, resists even the most profound disruptions of brain function. Short-term memory, then, does not involve protein synthesis but some other process, perhaps reverberating electrical activity which is sensitive to disruption. Long-term memory appears when the protein made in the cell body is fixed at the synapse imposing permanent modifications which resist disruptions.

But a curious discrepancy appeared between *in vivo*^{4, 18} and *in vitro*^{2, 18, 24-26, 41} studies of neuronal protein synthesis. Isolated non-perikaryal fragments support protein synthesis.^{2, 18, 24-26, 41} Further, many synaptic endings were

shown to contain mitochondria which, in non-neuronal tissues, have a self-contained protein synthetic system.^{48, 52} Were brain mitochondria different from those found in other tissues or was there some other explanation for the discrepancy? This problem became more acute when several workers reported that isolated brain mitochondria were not only capable of carrying out protein synthesis but they did this at a rate which was significantly greater than that of mitochondria isolated from other tissues.^{3, 12}

A resolution of this contradiction was required before the analysis of protein synthesis in the neuron could proceed. Careful studies of isolated brain mitochondria, including the mitochondria isolated from synaptic endings, revealed an ability to synthesize protein even in the absence of contaminations which plagued the earlier studies.^{3, 48} The synaptic endings themselves support protein synthesis *in vitro*.²⁴⁻²⁶ But synaptic regions of the neuron also contain lysosomes,²⁵ organelles rich in proteolytic activity. Thus, while synaptosomes synthesize protein, they also degrade it. It was shown, however, that amino acids so formed are employed in the synthesis of new protein.²⁶

These experiments clarified another rather curious aspect of neuronal nutrition. How do amino acids find their way to the synapse? Low molecular weight molecules, including amino acids, do not have ready access to the synapse. When injected into brain, they appear in the cell body but never in peripheral regions of the neuron unless they become associated with macromolecules.⁹ Many compounds show this peculiar behavior including the nonmetabolized sugar, xylose,³³ the model amino acid, cycloleu-

cine,⁴³ and even the inorganic ion, phosphate.³⁹ Rationalizations for this unexpected result include the supposition that the perikaryal plasma membrane is endowed with a very active transport system, so that low molecular weight materials are preferentially concentrated in the cell body; and/or that synaptic regions are far from capillaries so that material flowing into the brain from the circulation must traverse difficult and circuitous routes to find their way. The latter include movement through extracellular spaces; movement through the glia which surround the neuron; or movement through the neuron itself by somato-axonal flow. But somato-axonal flow may only transport high molecular weight compounds. Schmitt suggests that macromolecules move from the perikaryon toward the periphery by saltatory conduction on neurofibrils.⁵⁴ In his model, macromolecules are attached to the neurofibrillar elements which contain an ATPase. This enzyme uses the energy of ATP to promote the motion of the macromolecule to the next binding site and so on. If this model of transport is correct, a complicated three dimensional "fit" between the neurofibril and the moving macromolecule may be required for somato-axonal flow. The inability of low molecular weight molecules to associate with neurofibrils (because binding sites are absent) may account for their failure to move beyond the axon hillock, the region of the neuron where the neurofibrillar elements first appear.

These considerations led to the construction of the following model of neuronal nutrition.^{24, 25}

Amino acids are concentrated in the perikaryon where they are rapidly con-

verted into protein. Proteins move down the axon by somato-axonal flow. At the synapse, they are hydrolyzed by lysosomes into their constituent amino acids. These amino acids become the substrates for *in situ* resynthesis of synaptic protein.

An interesting consequence follows from this model. No acute *in vivo* experiment in which radioactive amino acid is injected and the disposition of labeled protein is followed can reveal synaptic protein synthesis. For, synaptic protein synthesis is proceeding with precursors that had been packaged into protein at some time before the radioactive amino acid had been injected, from protein originally synthesized in the cell body from nonradioactive sources.

If prepackaged protein is the precursor material for synaptic protein synthesis, so long as the perikaryon produces protein the synapse receives a complete complement of amino acids. Further, short-term variations in perikaryal protein synthesis would have little effect on synaptic supplies of amino acids. This buffering action against the temporary absence of essential amino acids may account for the resistance of the central nervous system to the effects of malnutrition except at certain critical moments in development when its growth enters an exponential phase. In teleological style (so common in biology), one may ask why evolution should place so much emphasis and expend so much energy on a system which accounts for perhaps 2% of the total protein synthetic activity of the neuron. It is tempting to speculate that this system, isolated from the main metabolic transactions of the neuron, holds so central a place in the economy of nervous function that only those organisms can survive which develop these special means

for the protection of synaptic protein synthesis.

CHARACTERISTICS OF SYNAPTIC PROTEIN SYNTHESIS —FUNCTION-STRUCTURE

The demonstration of an independent protein synthetic system at the synapse does not advance the analysis beyond a certain point. The question which remains concerns the ability of this protein synthetic system to confer plastic properties upon the nervous system.

At first sight, this seems improbable. No protein synthetic system other than that of the mitochondria has been identified in the synapse. But the protein synthetic apparatus of the mitochondrion is limited and its main function seems to be the replication of some of the elements of this organelle.⁵² The thought that this restricted and elementary protein synthetic system might serve so complex a phenomenon as neuronal plasticity seems difficult to accept.

However, brain mitochondria, including those which are isolated from the synapse, are unique.²⁶ Their protein synthetic system responds differently than do other mitochondria to inhibitors of protein synthesis and further, they make many more kinds of protein.²⁷ Finally, synaptic mitochondrial protein synthesis contributes some protein to the synaptic membrane.²⁷

The synthesis of plasma membrane by mitochondria permits a new view of neuronal plasticity. First, a mechanism for the adaptation of the cell membrane to environmental stimuli which is not exclusively regulated by the genetic information contained in the cell nucleus becomes a theoretical possibility. Second, mitochondria manufacture protein which becomes part of its membrane

structure.²⁷ Proteins of this kind have a number of remarkable properties. It has been shown that defects in mitochondrially synthesized protein can inhibit the activity of otherwise normal membrane-bound enzymes.^{62, 65} These membranous proteins have the ability to induce qualitative changes in the properties of membranes, for example, conferring oligomycin sensitivity on mitochondrial "inner membrane" ATPase.³⁰ Finally, Green believes that structural protein can assume a variety of conformations (shapes) each of which may confer new enzymatic properties on the final complex.⁴⁷ For example, it is possible that the change in adenyl cyclase activity produced by adrenalin (*vide supra*) results from the interaction of the hormone with structural protein.

What new qualities might be found in a membrane whose structural protein might, under some conditions, be changed? Could increased sensitivity or even changed responsivity to environmental stimuli result? If so, are the systems responsible for the synthesis of synaptic membrane subject to some kind of regulation, a regulation which can modify the rate of structural protein synthesis?

A particular property of brain mitochondrial protein synthesis is of interest. Synaptic protein synthesis is stimulated by sodium ion.^{2, 24} This response contrasts with other protein synthetic systems which are stimulated by potassium ion.^{38, 61} When the neuron discharges, an explosive influx of sodium ion occurs. Since brain mitochondrial protein synthesis is stimulated by sodium, a direct link between neuronal activity (discharge) and the stimulation of protein synthesis may be established. This relationship between function and pro-

tein synthesis and the contribution that mitochondria make to the synaptic membrane form an intriguing base upon which to develop and test a chemical theory of neuronal plasticity.

In the synaptic region there is a protein synthetic system which is at least partly independent of the nucleus of the cell. This system produces protein which in turn becomes part of the plasma membrane. The rate of protein synthesis is directly related to the rate of neuronal activity so that the structural configuration of the synapse is under the ultimate regulation of the functioning neuron itself. In the young organism, this process is manifest mainly in extension, though use, which regulates protein synthesis, is required even for growth. (In a number of fascinating experiments, it has been shown that cats born and raised in darkness are permanently blind—Wiesel and Hubel,⁶⁴ *vide supra*.) In the mature organism, use relates different synaptic endings one to another, or it bolsters the relationships determined by genetics. Facilitation of neuronal pathways is the consequence of this activity.

Since most neurons have multiple synaptic connections⁹ (there is one Purkinje cell in the monkey that has more than 300,000 synapses), a facilitation of a given pathway can influence a neuronal network so complex that almost any connection may develop. Perhaps this is the rationalization of the dominant focus experiments which show that the most bizarre and nonadaptive relationships between stimulus and response can be established with the proper "lessons."⁵⁸ In a very recent paper it has been demonstrated that a "dominant focus" cannot be established in the presence of inhibitors of protein synthesis.²²

The implications of these experiments

for the ethologist are profound. He proceeds by depriving an isolated organism of all information about a behavior that might be found in the environment. If the species characteristic behavior nonetheless appears, it is considered "innate" or, in the words of Lorenz, represents "genetically coded behavior."⁸⁷ But the coded behavior may have nothing to do with "information" contained in the DNA of the nervous system. It is conceivable that certain neuronal connections are established because the "genetic code," which directs morphogenesis, places certain neuronal tracts in close juxtaposition to one another. Activity establishes interactions between these

neurons because they are inherently "plastic," a plasticity which only appears as rigidity because of the high probability that a given connection will form. Further, those connections which are established by relating motor and perceptual functions will have a very high probability of formation because repeated activity promotes them. Is it possible that functions which have no motor correlates (thinking) and which, therefore to some degree, are divorced from the structural pattern of response imposed by anatomy are therefore the most plastic, the most changeable of the relations that can be established in the nervous system?

IV. CONCLUSIONS—QUANTITY BECOMES QUALITY

The fragmentary evidence that membrane reproduction depends, in part, upon its ability to organize new molecules into old patterns, a property of crystals known since antiquity, has been mentioned. Possibly, just as in the case of crystal formation, the pattern is stable just so long as the rate of replication is slow. Rapid membrane synthesis may overcome repetition just as sharp changes in the concentration of the chemicals in solution can force a reorganization of crystal structure. If these properties are assumed and if membranes are the sites of memory, long term memory can be understood. Further, this model requires no dichotomy between "short" and "long" term memory. If persisting synaptic modification depends on a minimal quantitative change in protein synthesis, one might anticipate that the frequency of synaptic discharge is a crucial factor in fixing a memory. The necessary repetitions could be achieved over a period of time by

repeated but discontinuous stimulations or in a much shorter time by an intense bombardment of stimuli. Perhaps tetanic stimulation is an example of the latter condition. It is certain that the affective state profoundly influences the time required to "fix" memory. Animals taught to perform a task while receiving a small electrical shock to their feet "fix" memory in as little as two minutes while controls taught the same task without electric shock require 30 minutes to "convert short term to long term memory."⁷ Since affect also profoundly influences the electrical activity of the brain, "alerting" an animal may be equivalent to increasing the rate of synaptic discharge and thus producing the required quantitative change in a short time.

If the neuron has a continuing ability to establish new organizational patterns and if these patterns depend on use, the dichotomy between "functional" and "organic" loses much of its former sig-

nificance. Neuronal function becomes protein synthesis. Protein synthesis becomes membrane modification. Mem-

brane change becomes a facilitated pathway which organizes perception and behavior.

V. EPILOGUE—REACHING FOR PSYCHIATRIC IMPLICATIONS

It is interesting that all of the somatic therapies useful in psychiatry modify synaptic membrane activity. The phenothiazines markedly inhibit synaptic protein synthesis¹⁴; energizers may stimulate this activity. Electric shock, too, has its principal impact upon synaptic discharge and results in long term changes in the rate of protein synthesis.³⁴ Future investigations may discover means by which pathways can be selectively activated or deactivated, not only by learning but with the aid of chemical interventions. The modification of behavior based on the chemical-functional model outlined above may then become possible.

It is said that when Newton was asked how one man could accomplish so much he answered, "I see so far because I stand on the shoulders of giants." Research into mental disorders has not stood upon such shoulders. This is made painfully evident in Kety's illuminating critique of the biological research into psychiatric syndromes.³⁵ While he concentrates on methodological questions and problems of diagnosis and replicability, it may well be that the major problem is our inability to pose relevant questions. The work he reviews presses for solutions, no matter how ephemeral its rationale, because "something has to be done." It climbs upon the shoulders of pygmies where it cannot see over the forest of unsubstantiated claims and biological nonsense, for no giant is available.

Perhaps the investigations of neuro-

physiology and biochemistry have the potential of growing into the tall edifice from which a new perspective can be gained. How the synapse is nourished cannot be without significance in the development of appropriate neuronal connections. The equivalence of nutrition and function in the synapse suggests that the brain does not live by bread alone. The ability of neurons to establish almost unlimited connections when appropriately stimulated cannot be without meaning in psychological and intellectual development. This is a long way from an understanding of psychological disorders but we may have to travel this difficult road before the relations between structure and function, between nutrition and development, between experience and activity can be unraveled.

In summary, the study of the cell membrane promises insights into the mechanism by which quantitative changes in a few molecular species may result in the production of perpetuated qualitative modifications. The biology of individual history may be localized at the cell membrane.

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RESEARCH

INTENSIVE PSYCHIATRIC TEACHER COUNSELING IN A LOW SOCIOECONOMIC AREA: A CONTROLLED EVALUATION

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The behavioral responses of school children in a low socioeconomic area to maximum stimulation and psychiatric counseling by their teachers is reported. While normal and disturbed children differed significantly in their recorded behavior, no overall therapeutic effect was observed one month, three months, or 12 months after treatment.

Today, there is increasing awareness that the processes involved in learning and the formation of personality in children are intimately related. The development of one, normal or abnormal, influences the development of the other. Several authors^{10-12, 27, 33, 34} in recent years have presented evidence for the significant relationship between reading retardation and psychopathology. Furthermore, these deviant behaviors have been found to be significantly related

to the race and socioeconomic background of the child. Both Deutsch¹⁰ and Stennett³³ found that the socially deprived child tends to fall further behind in academic performance as he passes through the educational system, losing in fact an average of 1.9 years of academic standing within a six-year period when retested on the same achievement tests at regular intervals. Other authors^{10, 30} present data which show the socially underprivileged child to

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have more worries pertaining to school and to remain disturbed over a period of at least two years following the initial observation.

Biber⁸ has stressed the "ego developing" task of the school: providing the child with knowledge which will enable him to interact successfully with his environment. The teacher, additionally, has been seen to be an important adult and model,¹ one whose relationship with the child can be important for the growth of positive feelings towards oneself and others.

There is also, besides the correlation between emotional and cognitive development, strong evidence that normal functioning in the school situation has important prognostic implications with regard to the future mental health of the individual.^{25, 31} The number of behavior symptoms displayed by children in school have been found to correlate highly with the severity of psychological illness,¹⁷ and teachers are able to detect these symptoms with a high degree of reliability.^{5, 18, 19, 28}

Repeated experiences have documented the general failure of the classical child psychiatric clinic to alleviate substantially the psychological ills associated with poverty and its resulting cultural and emotional deprivation in children. Classical psychiatric treatment requires both a high degree of abstract reasoning and a great expenditure of time, neither of which the culturally deprived child can provide.^{10, 11, 21} The school, on the other hand, provides a fairly consistent environment for at least five hours per day and an immense number of potentially therapeutic encounters between teacher and pupil, since the normal child spends approximately 12,-

000 hours in the classroom up until age 17. Within this environment there is the added opportunity to modify naturally occurring behaviors immediately and to eliminate the need for the more complex cognitive behaviors required in formal psychotherapy.

Various attempts have been made to intervene in the apparently vicious cycle whereby emotional difficulties lead to increasingly crippling cognitive retardation, which in turn exacerbates the emotional problems. Three major methods have been employed:

1. *Therapy is given to the parents of the difficult children*, based on the assumption that the teacher can produce little improvement in the school while the parents undo it at home. Gildea and her group^{7, 8, 14, 15, 22} have been the main investigators of this approach and they report positive results when working with middle-class families, the parents of which place a high premium on education and the values of the school. Lower-class parents, however, have shown little interest in such counseling groups.²²

Hereford¹⁹ and his colleagues recently published an investigation in which they claimed remarkable results after working with 30 parent groups for six weekly sessions. The changes ranged from positive shifts of parental attitudes toward developmental problems and their children's behavior in general, to an increase in sociometrically determined peer popularity among the children whose parents participated in the groups. The author claims that all socioeconomic groups were included in the sample and that it was the lowest socioeconomic families that showed the greatest change. However, he gives no specific

data to support these claims. He also states that the observed changes were independent of the number of sessions attended. The same significant improvement was said to occur whether the parents had attended only one or all six meetings. This gives the findings a somewhat questionable validity.

2. *In the second method, counseling is directed at the teachers* who are involved with the individual child. This approach is based on the assumption that it is either too cumbersome to form parents groups or that the parents simply cannot be motivated for treatment, and since teachers have problems with the children it should be they who receive guidance.

Bower^{5, 6} and his group have used this method in California, offering consultations to teachers by trained laymen as a means of overcoming the teachers' difficulties in dealing with disturbed children. It is claimed that this procedure has been successful in a great number of cases regardless of the socioeconomic background of the children, but no data are presented.

Educators^{18, 24, 28} have also repeatedly stated that the behavior of maladjusted children whose homes cannot be reached can be modified in the school with the help of specific methods. These methods vary from author to author, who offer little concrete guidance, especially since none presents quantitative data to evaluate their results.

Recently, a number of psychologists^{2, 4, 32, 35, 36} have begun to use behavior therapy with operant conditioning techniques to treat a variety of conduct problems in special classes. The teachers are frequently employed as co-therapists. The studies show statistically significant

changes in isolated behaviors of the children (who are, however, often of pre-school age) but usually lack description of the extent of carryover to other behaviors which were not directly modified. Also, there are no data on the duration of the improvement. Due to the fact that these treatment methods require somewhat elaborate technical procedures with specialized classroom settings, an untreated control group is seldom included in such studies, and those conducting the study usually rely on using the patient as his own control.

3. *The third method involves therapeutic intervention with both teacher and parents*, since between them they represent the greater part of the child's life space. This approach would appear the most natural one, and it has been used with apparent success by at least two investigators.^{27, 29} Neither author presents objective data nor, it seems, did either author deal with children from the lower socioeconomic strata where parental cooperation for long-term counseling is often not obtainable.

In summary, it appears that all the above mentioned attempts to ameliorate deviant behavior in the school-aged child have been judged successful by their adherents although the data they present are mainly anecdotal and hence do not lend themselves easily to an objective comparison. When adequate statistical evaluations are reported, they center around isolated behaviors and utilize techniques not easily practicable in the nonspecialized classroom.

The present report, the first of a more extensive investigation, is concerned with an objective examination of treatment results on a group of 20 normal and 40 disturbed children from a low

socioeconomic background who attended a regular school. The parents were not involved in treatment, as eliciting their cooperation would have been a major undertaking precluded by limitations of time and financial support.

SETTING—THE SCHOOL

The study was carried out in an English-speaking elementary school situated in one of the most homogeneously depressed neighborhoods of Montreal. The school had been serviced by a psychiatric resident on a consultation basis for three years, during which time a mutually trusting relationship between the school's teaching staff and McGill's psychiatry department had been established.

The area, which is very close to the teaching hospitals of McGill University, is comprised typically of two-story brick houses of which, according to a recent survey,⁹ 76% are poorly heated, 52% have no hot water, and 30% have no running water either hot or cold. The mean age of the buildings is 70 years, with 70% of the dwellings in poor or very poor repair. The average family living in this district in 1965 had an annual income of \$2,780 and paid \$45 a month rent. While the conditions are reminiscent of a typical North American slum, the area has no narcotic problem with all its associated delinquencies.

The school has a population of 350 children, two classes for each grade (kindergarten through seventh grade), and two classrooms for educable retarded children. Each class has between 20 and 25 pupils, of whom 50% are Negro. Only 3% of the students here traditionally complete high school while

79% of the students in the rest of Montreal do so.

The 24 teachers of the school are all fully qualified, 3 holding a B.A. degree and 5 having special training in such subjects as music, crafts, sports, and home economics. One social worker serves the school along with 21 other schools, but she devotes about 8 hours per week to the area. One nurse comes two half days during each week, and a general practitioner visits one morning per month.

SUBJECTS

Each class teacher of the 10 classrooms of the third through seventh grades selected four children whom he/she considered to be most disturbed in general conduct and learning. Two well-behaved, optimally working students in each class were chosen as controls, giving a total sample of 40 disturbed and 20 normal children.

The disturbed children frequently came from extremely deprived homes which in general fit the categories described by Pavenstedt,²⁶ who differentiates between the "multiproblem" or "fringe skid" family which is without any regularity and lives in permanent chaos and the "upper lower class" family which has some cohesion and responds to help. The distribution of children in the disturbed sample between these two types of families was 12 and 28 respectively. The presenting complaints of the problem children ranged from disturbance of the teaching process through inability to profit from instructions because of cognitive and behavioral handicaps, to outright delinquencies such as stealing from the teacher and destruction of property.

Each child had a score on the Ham-

mond Nelson Group IQ Test and a record of absences from school during the preceding 12 months. None of the children had any gross physical abnormalities, and all lived within a family setting. The socioeconomic class of each subject was determined by the father's occupation, or in his absence by the mother's or the guardian's occupation, using the scale of Hollingshead²⁰ as a guide line.

ASSIGNMENT TO EXPERIMENTAL AND CONTROL GROUPS

The senior author, in consultation with each classroom teacher, assigned two of the four children with the worst behavior problems in that class to the treatment group and the other two to the nontreatment group. The decision as to who was going to be treated had, unfortunately, to be geared to providing the maximum relief to the teacher, i.e. the children receiving treatment were frequently the most annoying and disrupting influences in the class. Attempts were made to match the groups for sex and IQ as far as this was possible.

INITIAL RATING OF EACH CHILD

Familiarization: Two graduate students in psychology and sociology were asked to spend three half days in an assigned classroom and simply observe the general activity. The purpose of this was to familiarize the pupils to the observer's presence. No data were recorded during this time.

Baseline: Following this initial period the observers began to record the frequency of occurrence of 11 types of behavior for each child, using an adaptation of the method developed by Becker and his colleagues.² The adaptation consisted of adding four categories and

modifying two others so as to encompass as much behavior as possible. The following types of behavior were recorded: (1) getting out of seat, (2) talking, (3) aggression towards others, (4) making disrupting noise with an object, (5) turning around, (6) day-dreaming, (7) doing other than required activity, (8) commenting and vocal noise, (9, 10) positive or negative teacher contact, (11) paying attention to task. Child I would be observed for 20 seconds and his scores noted on a special scoring sheet during the ensuing 10 seconds, then the observer would move on to Child II, and so on. After each of the six children in a class were observed once, the procedure was repeated until each child had been observed for between 200 and 250 20-second periods over a two-week interval.

Each observer visited his classroom on the same weekdays throughout the investigation so as to make the measurements over time and children comparable. Both graduate students were given initial training by the principal investigator in scoring the pupils' behavior to the criterion level of 90% agreement with him on all code items. The principal investigator also spent a considerable time in the classroom observing the children's conduct and the teacher's response to it.

TREATMENT

As all these children had multiple difficulties, treatment was aimed at using all available resources to their maximum efficiency in the following:

Team Approach: The principal investigator, the social worker, and the psychiatrist, at times assisted by the school nurse, spent an average of two to three hours per week together and prepared

an individual treatment approach for each child after all available background data had been collected. The measures decided upon were variable and included: home visits by the social worker; home visits by the nurse; the provision of an empty classroom with a teacher who could function as a holding situation in times of serious disturbance; medication; and general planning of disciplinary action by the school administration.

Teacher Counseling: The principal investigator had almost daily meetings with the class teachers during which an explanation of the behavior of individual children was sought and methods of remediation were discussed. The reactions of the teachers to misbehavior were, as far as possible, made into therapeutic encounters between teacher and child by the teacher either praising non-deviant conduct, isolating an uncontrolled youngster, or merely understanding previously annoying devices as calls for help. In addition, teaching methods were adjusted as much as the school system permitted. More emphasis was put on immediate rewards; the teacher's expectation of the children's purely academic performance was lowered, since most of the youngsters were retarded in their ability to comprehend abstract materials; more realistic learning models were suggested (increasing the children's vocabulary by talking with them about juvenile court procedures rather than about middle-class Dick and Jane).

Tutoring: Twenty-five eleventh grade students from three local private high schools volunteered to give each child in the treatment group two to three hours a week of general enrichment. This consisted of each student meeting

his assigned child on specific days in a local church hall and working with him either on school work or other activities potentially helpful to his general functioning (visiting museums, circus, zoo, etc.). All the tutors had been given about 10 hours of initial training by special adjustment teachers, remedial therapists, social workers, and psychiatrists in an attempt to prepare them for their work with the children. In addition, the tutors were seen as a group every two to four weeks by the principal investigator and the remedial teacher to support them in their work. The class teacher of each child was in close contact with the tutor at all times, briefing him on the school work and any specific academic difficulties of the child.

Miscellaneous: Four children were given tranquillizing medicine and three children were interviewed one to three times by the psychiatrist since the available information was not sufficient to explain their behavior. None of the other children were ever seen individually by the psychiatrist and only two mothers had an interview with him.

ASSESSING TREATMENT

Evaluation was done in four phases (additional to the baseline observations).

Three to four weeks after initiation of the treatment program the same two graduate student observers repeated another two weeks' observation of all children (treated, untreated, and controls). Following this period of observation the psychiatrist terminated his discussion with the teachers and the team about the children of this particular class, although the tutoring continued until the end of the school year.

Each classroom was then revisited by its observer one month and three months

after termination of treatment for another series of 180 to 240 observations per child.

A long-term followup was carried out one year later, at which time it proved impossible to employ the same observers who had made the earlier observations. Also, out of the initial 60 pupils, 11 had gone on to high school, 3 had been placed by the principal investigator and/or the court into institutions or treatment centers during the remainder of the previous year, and 8 had left the area, leaving a sample of 38 or 64% of the total.

At no time during the collection of data did the observers know to which treatment category each child belonged.

RESULTS

Comparison of the Control and Experimental Groups in Relation to the Background Variables: As seen in TABLE 1 the experimental and control groups were well matched for age and sex, but showed a trend ($p < .10 > .05$) towards differences in their socioeconomic back-

grounds with the control children coming from economically somewhat superior homes.

TABLE 2 records various background variables of the three groups such as school data, family structure, and psychiatric history. On all measures there were significant differences between the two disturbed groups and the control group but never between the two disturbed groups. The mean IQ of the control group was significantly greater than that of both other groups ($p < .01$) but there was no difference between the treated and untreated groups ($t = .82$). The controls had fewer school absences than the disturbed groups but this did not quite reach significance ($p \approx .10$); there were no differences between the two experimental groups ($t = 0.18$). The disturbed children lived significantly less often with their natural parents ($X^2 = 8.73$, $p < .02$) but rather with relatives, foster parents, or merely "friends of the family." They had more often lost a parent through death (eight fathers and two mothers), been born out of wed-

Table 1
BACKGROUND VARIABLES

	AGE	SEX		SOCIOECONOMIC CLASS	
		Boys	Girls	III-IV	V
CONTROLS ($n=20$)	10.90 S.D. 1.80	12	8	7	13
UNTREATED ($n=19^a$)	11.38 S.D. 1.42	13	6	3	16
TREATED ($n=18^a$)	11.05 S.D. 1.74	11	7	1	17
	$F=.42$ $p=NS$	$X^2=0.35$ $p=NS$ $df=2$		$X^2=5.80$ $p<.10>.05$ $df=2$	

^a One untreated and two treated children could not be included in the analysis as they missed one complete observational period.

Table 2
SCHOOL DATA, FAMILY STRUCTURE, AND PREVIOUS PSYCHIATRIC HISTORY

	IQ	DAYS OF ABSENCE PREVIOUS SCHOOL YEAR	GRADES REPEATED None or More	LIVING WITH		PARENTAL STATUS		PREVIOUS PSYCHIATRIC CONTACT	
				Both Parents	Other	Married or Living Together	Separated, Divorced, or Parent Dead	None	Yes
CONTROLS (n=20)	105 S.D. 11.5	8.4 S.D. 11.2	19 1	18	2	18	2	20	0
UNTREATED (n=19)	97 S.D. 11.1	16.4 S.D. 17.0	16 3	9	10	10	7	12	7
TREATED (n=18)	93 S.D. 9.7	15.5 S.D. 12.3	10 8	10	8	10	8	9	9
	$F=5.68$ $p<.01$ $p_{1,2}<.05$ $p_{1,2}<.01$ $p_{1,2}>.2$	$F=1.33$ $p=.10$ $p_{1,2}<.25$ $p_{1,2}<.20$ $p_{1,2}>.25$	$X^2=9.62$ $p<.01$ $df=2$	$X^2=8.73$ $p<.02$ $df=2$	$X^2=7.16$ $p<.05$ $df=2$	$X^2=11.03$ $p<.01$ $df=2$			

lock with the mother remaining unmarried (four children), or experienced multiple separations or divorce (five children) than their control peers (one death and one illegitimacy). Their often long-standing psychological difficulties were documented in frequent previous contacts with our psychiatric clinic ($X^2=11.03$, $p<.01$). The psychiatric files usually suggested emotional deprivation as the source of the child's difficulty but generally had few realistic suggestions for treatment.

Pre and Post Differences in Behavioral Ratings: An attempt was made to validate the observational measures used in the study by comparing the baseline ratings of all three groups on each behavior item, using analyses of variance. The value of t was calculated for observations of control vs. untreated, control vs. treated, and treated vs. untreated children (TABLES 3 and 4) when the F ratio was significant. The statistical evaluations of behavioral changes of the treatment were based on nine of the 11 initially observed behaviors since two—Commenting and Vocal Noise; Aggression Towards Others—occurred less than 1% of the time in all groups and hence were deleted from the analysis.

In all but one area (Turning Around) the control children showed significantly superior performance to either of the disturbed groups, while these latter showed no initial difference between them except on one item (Daydreaming). Here the treated children scored significantly lower ($t=2.67$, $p<.02$) than their untreated peers. These results suggest that the behavioral measures differentiated well between lower-class children who function normally in a school and those who exhibit difficulties,

Table 3
INITIAL BEHAVIORAL RATINGS IN PERCENT FREQUENCY

	ATTENTION		GETTING OUT OF SEAT		TALKING		TURNING AROUND		DAYDREAMING	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
CONTROLS (n=20)	81.6	9.7	0.8	1.5	5.0	4.1	2.7	2.4	6.1	5.6
UNTREATED (n=19)	53.0	14.0	3.4	4.1	10.5	7.4	4.1	3.8	19.6	10.0
TREATED (n=18)	59.0	18.0	3.0	6.3	12.0	10.4	4.7	5.6	11.7	8.5
	F=27.88 p<.001 p _{1,s} <.001 p _{1,s} <.001 p _{2,s} <.2		F=5.98 p<.01 p _{1,s} <.05 p _{1,s} <.1>.05 p _{2,s} <.2		F=4.69 p<.05 p _{1,s} <.05 p _{1,s} <.05 p _{2,s} >.2		F=1.34 p=NS p _{1,s} >.2 p _{1,s} >.2 p _{2,s} <.2		F=15.2 p<.001 p _{1,s} <.001 p _{1,s} <.02 p _{2,s} <.02	

and they imply that the method has some validity.

In the evaluation of treatment effects, two-way analysis of variance (split plot design) was used. There were two factors:

1. Treatment group with three levels (normals, untreated, treated). This factor was uncrossed and subjects nested in it.

2. Time factor with five levels (base-

line observations; observations four weeks after initiating treatment; observations one, three, and 12 months following termination of treatment). This factor is crossed with repeated measures.

There were 20, 19, and 18 subjects in each treatment group except in the long-term followup where there were 13, 14, and 11. Because of the smaller number of subjects at long-term followup, two separate analyses of variance

Table 4
INITIAL BEHAVIORAL RATINGS IN PERCENT FREQUENCY

	DOING OTHER THAN TASK		TEACHER CONTACT				DISRUPTING NOISE WITH OBJECT	
	Mean	S.D.	Positive		Negative		Mean	S.D.
			Mean	S.D.	Mean	S.D.		
CONTROLS (n=20)	1.0	1.7	3.8	2.5	0.1	0.4	0.2	0.5
UNTREATED (n=19)	9.7	14.2	5.5	2.9	1.6	2.0	1.1	1.9
TREATED (n=18)	6.1	8.8	5.8	3.5	0.9	1.7	0.9	1.5
	F=9.52 p<.01 p _{1,s} <.01 p _{1,s} <.01 p _{2,s} <.2		F=5.23 p<.01 p _{1,s} >.05<.1 p _{1,s} <.05 p _{2,s} <.2		F=9.58 p<.01 p _{1,s} <.01 p _{1,s} <.05 p _{2,s} <.1		F=3.43 p<.05 p _{1,s} <.05 p _{1,s} <.05 p _{2,s} >.2	

were run, one with five levels on factor B and the other with four levels ($n=57$). The former included only those subjects who had all five observations ($n=38$). Since the results of these two analyses were similar for the first four observation periods, they will be discussed as if there had been a single analysis.

The rationale for using the analysis of variance was that if treatment were having an effect, the relationship of the means and their variances among the various groups existing at baseline should change with time though not necessarily at more than one point in time.

In none of the observed behaviors did the three groups show a significant change with respect to each other at the end of treatment—one, three, or 12 months later. Of course, this also implies that initial significant differences between the emotionally disturbed groups and the controls persisted.

Comparison of Missed School Days:

The days of absence were computed on a monthly average, taking the previous school year as a baseline (see TABLE 2). The average absence per month following treatment was then subtracted. The assumption was that as the well-adjusted child is a more regular school attender, a youngster who has improved in his general functioning would show improvement in this area as well. The findings indicate a somewhat more regular attendance of the treated vs. the untreated children although it does not reach significance ($F=2.49$, $p=.10$).

Global and Clinical Ratings: Following the baseline observations, the principal investigator asked each student observer to place each child in the disturbed or control group or indicate that he was unable to decide. In only three

cases was this "guesstimate" inaccurate, one disturbed child being rated as normal and one disturbed and one normal child as "unable to decide." When the observers were asked to rate the children three months after treatment as either improved, worse, or unchanged, a significantly higher number of treated children were seen as improved when compared with the untreated group ($X^2=7.37$, $p<.05$, see TABLE 5). No changes were seen in the control group.

Table 5
GLOBAL RATINGS BY OBSERVERS

	SAME	IMPROVED	WORSE
CONTROLS	20	0	0
TREATED	5	13	1
UNTREATED	11	5	2
		$X^2=7.37$ $p<.05$ $df=2$	

DISCUSSION

The results of this investigation will be discussed under two headings: methodological and therapeutic.

Methodology

The poor IQ matching of the control vs. the disturbed groups occurred despite attempts to avoid a selection of the brightest children as controls. Unfortunately, there were usually more than four disturbed children per classroom, and finding "normals" of low average intelligence proved at times difficult. There remains the additional possibility however that the disturbed children were merely penalized by the verbally oriented group intelligence tests and had in fact an innate intelligence comparable to the control group.

The differences in classroom behavior set out in TABLES 3 and 4 give good evidence that the method of measurement discriminates consistently between well and poorly functioning school children from a low socioeconomic background, confirming the studies of disturbed children by Becker et al.² and of normal and disturbed children by Werry and Quay.³⁵ The one nondifferentiating behavior (Turning Around) could well be understood as being independent of school adjustment and more dependent on the location of the child in the classroom.

The fact that a different student observer one year later rated the control children almost identically and showed only a slight difference in the assessment of the disturbed children indicates the diagnostic reliability of the behavioral measures and/or the persistence of diagnostic status. The trend to rate the disturbed children as functioning somewhat better one year later is most probably due to attrition of subjects. The raw data demonstrate clearly that the children who were lost for followup rated above the mean initially, and their expulsion thus undoubtedly contributed to this general slight improvement.

An interesting finding which throws some light on the secondary gains of disturbed behavior is the significantly higher number of "good" (i.e. encouraging, praising, attending) as well as "bad" (scolding, reprimanding, etc.) teacher contacts the disturbed children had. Whereas the increase in negative contact would be expected, the data also demonstrate clearly the positive reinforcement which deviant behavior elicits from a conscientious teacher (see TABLE 4). Similar observations had been made by Werry and Quay.³⁵

Treatment

An evaluation of the treatment results is more difficult. It appears obvious that the truly immense efforts made by the treatment team—the psychiatrist spent about 300 hours and the tutors a sum total of approximately 1,500 hours, with the principal, social worker, and nurse adding another 200 hours, on 20 children—did not produce a marked change in the children's functioning. This overall failure may be explained in several ways:

1. The treatment was without effect, perhaps because of the shortness of its duration or the inability of teachers to change their behavior toward the children.

2. The treatment effect was too small with respect to those of other variables such as CNS status, home environment, other social variables, unsuitability of the school curriculum for children from this background, and the age of the sample (children of eight and older perhaps being relatively resistant to any therapeutic endeavor).

3. The method of measurement was invalid and did not detect the changes occurring with treatment. This seems unlikely since Becker et al.² and Werry and Quay³⁵ did show treatment effects with a basically similar method.

The investigators were constantly aware of the amount of potential distrust dividing the world of the middle-class teachers and their pupils, although the former were generally devoted and had a great deal of empathy and understanding for their pupils. The teachers, however, appeared at times to be victims of a curriculum designed for middle-class children and were hence unable to ensure the success necessary to facilitate an increase in self-esteem in

our patients. This too may have militated against successful treatment.

The question of age and duration of treatment is very pertinent. The general trend to combat deprivation and enhance academic achievement has moved away from the school years to the age groups 3 to 6. We did not include the first and second grades in our sample because their classroom activities were much less structured, most "deviant" behaviors appeared still "legal," and little real work was asked of the children. The data, however, gave no evidence on inspection that the 8-and-9-year-old children did any better than the 13-year-old ones.

The duration of treatment was felt to be much too short by all members of the treatment team. It appeared obvious that many of these children, in order to make successes of themselves, had to overcome their inherent reluctance to be different from their parents. They had to realize that if they succeeded, their own parents in some way became "failures" and hence ceased to be a natural source of identification. We felt that some children were unable to do this and, in order to maintain the fantasy that their life was good, would attempt to degrade the rest of the world so as to make it look worse than their own environment. Although these thoughts are speculative they point to the desirability of involving both home and school in any rehabilitation program, a task which we were not equipped to handle.

Our method of measuring behavior, while objective and reliable, obviously does not encompass all behavior since it precludes psychodynamic analyses and nonquantifiable information. Here the global ratings of the student observ-

ers (see TABLE 5) give some identification that a positive change in the treated groups did perhaps occur, suggesting some therapeutic effect. These global ratings may also indicate that atomistic, so-called objective measures may be inferior to the integration of diverse information which is performed by the human brain to form a clinical impression.

We are attempting a clarification of some of the above points by presently repeating the same study in a socio-economically superior district. Here the curriculum is more in concordance with the ability of the pupils and the teachers more truly representative of the culture and value propagated at home and hence potentially more useful as therapeutic agents.

SUMMARY

The classroom behavior of 20 normal and 40 disturbed children from a low socioeconomic neighborhood school was rated objectively by observers using a frequency counting technique. The method of measurements discriminated significantly between normal and disturbed children in all but one category of behavior.

Following an initial or baseline observation period, 20 of the 40 disturbed children were given an intensive period of treatment. All the children (apart from a few dropouts) were reevaluated at the end of treatment as well as one, three, and 12 months later. There was no overall treatment effect, though independent global ratings did suggest some benefit from treatment.

The findings are discussed in view of the limitations inherent in the school system, duration of treatment, and the involvement of the total family.

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TEACHERS OF DISTURBED PRESCHOOL CHILDREN: AN ANALYSIS OF TEACHING STYLES

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Observations of two experienced teachers of disturbed children suggest the possibility of developing a coding system for differentiating between teaching styles. This paper presents pilot efforts, and poses questions about philosophies of teaching in therapeutic nursery schools which may help to refine training methods in this relatively new field.

Another treatise on what every good teacher should do and be is not needed. In the field of preschool education such rhetoric is especially tempting. What is needed is an accurate method of describing what a teacher of young children does. A way to delineate components of teacher style—the characteristics which distinguish different teachers—is also needed.

Because we were involved in a training program for teachers of emotionally disturbed preschoolers, the problem of teacher style haunted us. We made an assumption: that one of the important things a disturbed child gets from his attendance in a therapeutic nursery

school group has to do with his interactions with the teacher and the choices she makes. We needed a frame of reference for conceptualizing different aspects of what a teacher does. In addition, we needed a shorthand, or coding system, so that we could more easily place our observations into different categories of teaching style.

We looked into the literature and found that most previous research on teaching styles could be divided into three categories: work done in regular classrooms with school age children; work done with disturbed children; and work done in preschools. By far the vast majority of work has been in regular

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classrooms, where the teaching-learning process is focused on instructional content. Most of the transactions are verbal and are between persons who remain in relatively fixed physical positions in the classroom.

PREVIOUS WORK

In Regular Classrooms. The work of Flanders;^{5, 6} Lewis, Newell and Withall;⁸ and Amidon and Hunter¹ exemplify the attempt to categorize interaction processes in elementary, secondary and college classrooms. Flanders' work in this area is perhaps most frequently referred to, and was unique because it introduced a recording method which preserved the sequence of events. He classified verbal instructional behavior into ten categories, four involving indirect teacher influence (e.g. accepts feelings, asks questions, etc.), three involving direct influence (e.g. lecturing, giving directions, etc.), two involving student talk (e.g. whether the student initiated something, or spoke in response to something initiated by a teacher), and one called "silence or confusion."

The observer memorized the categories by number. As he watched he made a judgment about the type of interaction that was occurring and wrote down a coding number every three seconds. At the conclusion of the observation period, his notes consisted of a series of numbers which were later transferred in overlapping pairs to a 10 X 10 matrix. Various areas on the matrix would then reveal prevailing patterns in an individual teacher's style of interaction. For instance, if in a particular classroom a typical interaction involves a brief teacher question followed by a brief student response (a drill pattern) certain cells on the matrix would receive a large

number of tallies. Other workers, such as Amidon and Hunter,¹ have expanded and refined Flanders' basic method.

This newly found ability to categorize and quantify teacher behavior is an important landmark in the study of teaching and in the supervision of teachers. Teachers themselves have used Flanders' techniques as a way of becoming more reflective about their own work. Teachers learned to code tape recordings of their own and their colleagues' work. With this information they could then begin to practice introducing certain types of interaction more consistently in their classrooms. The technique also enables workers to study the effect of particular types of teacher interaction on children's behavior and achievement.

These existing techniques have limited applicability where young children are concerned. In preschools the children are less verbal. The classroom is not so fixed or formal. The teacher's physical positioning in the classroom, her movements toward and away from activities and even the direction of her looking and giving attention, become as important as the things she says and what she does with materials and curriculum content. Physical guidance and restraint are common. Actual demonstrations with materials, and concrete non-verbal help in accomplishing tasks, are frequent.

Work with Disturbed Children. Many of these technical problems of coding teacher behavior with preschoolers are also present with disturbed children. An example of an attempt to look at teacher-child interaction was undertaken at the Children's Day Treatment Center⁴ in New York City. Two experienced teachers, judged highly competent but remarkably different in style, were observed with their groups of emotionally

disturbed children, age 5½-9. Seven 15-minute observations were made over a year's time, and typescripts of these observations were analyzed. (Teachers were also asked to make a personal statement about what they tried to communicate to children.) From the analysis, similarities and differences in their styles were noted descriptively, and statements about the therapeutic value of placement in their classrooms were made. The reporting is vivid, and includes brief examples of actual classroom interaction, but lacks an objective quantifiable method of analysis.

Preschool Work. A study by Anderson² in 1939 explored domination and social integration in teacher contacts with children in regular kindergarten classes. Nineteen categories (such as relocating or reseating a child; showing disapproval or placing blame; participating in a joint activity with a child) were memorized by the observer. A prepared observation sheet was used for each five minutes of observation time. The sheet had vertical columns giving all the children's names, and one called "group." Horizontal rows held the categories of teacher contact. Every time the teacher made a contact of any sort the observer entered a tally in the proper square. A ratio of dominative to integrative contacts for each teacher was arrived at. It was possible to show the total number of contacts made by the teacher herself, and what kind of contacts each individual child and the group received. This was an important study which influenced workers such as Flanders, but had little effect on the preschool field.

A recent impetus in this country for studying styles in preschool teachers seems to be growing out of Head Start

Research and Evaluation Centers. For example, E. Kuno Beller,³ at Temple University, is conducting related studies in Head Start classrooms. He has developed a series of rating scales for factors he feels are important in creating certain classroom climates: closeness-detachment; distinction between work and play; prearranged versus flexible classroom arrangement; and a number of others. He has been able to show that ratings on these scales successfully differentiate between more and less "successful" teachers as selected by their supervisors.

Gardner and Cass,⁷ in England, have recently published a study about the role of the teacher in infant classes (age 5-7) and nursery schools. Observers took samples of teacher behavior during free activity periods. From the process notes, these were categorized under approximately 80 headings. For example: "actions concerned with provision of intellectual stimulation or imparting information" (12 subdivisions); "rendering physical care, protection or comfort" (3 subdivisions); "concerns for maintaining discipline and control of behavior" (19 subdivisions). This study is reported in considerable detail, and preserves some actual descriptions of things the teachers said and did. A simple counting technique was used to show the prevalence of various types of interaction, which were later related to age factors in the different groups of children.

We did not feel that any of the above-mentioned models would serve our purposes. We were searching for a simpler method and one which would be sensitive to group process factors as well as teacher-child interaction patterns. Since the therapeutic nursery school groups

were smaller than regular classroom groups (five children), we felt it would provide a useful opportunity to make observations of teaching style.

METHODOLOGY AND RESULTS

A method for analyzing teacher style must be simple and must be capable of revealing significant and systematic differences in teaching style. Our goal was to isolate systematic rather than random or transitory characteristics in the way a teacher interacts with the children she teaches. We assume that in general (not perhaps every single time) each teacher, when confronted with a particular kind of event in her classroom, will have a characteristic way of responding. The method we have been developing is not sensitive to every aspect of teacher style. It focuses on a limited number of features of the teacher's interaction, which are readily observable and which can be categorized without recourse to inferences or judgments about the latent content of her behavior or verbalizations. This is necessary if a method is eventually to be both reliable and useful.

Our data were obtained on the basis of ten-minute observations recorded at the same time each day by an experienced professional who sat in an observation booth and wrote down all that the teacher said or did. The observer attempted to indicate to whom the teacher spoke and to whom her physical movements or attention had reference. Initially it had seemed impossible to record everything the teacher said and did. Therefore we first began by focusing on a particular individual child in each group. We were interested in all of the teacher's behavior in relation to that child, and other behavior which may possibly have affected that child even if it was not directly focused on him. How-

ever, as the observer became more experienced the observations became more complete. It was possible to return to our original goal—a more general view of the teacher's total presence in the classroom. For this reason we have chosen observations made late in the school year when the observer had become more proficient.

The two teachers studied were teaching in therapeutic nursery school groups in the Greater Boston area. These groups met two or three half days per week. Enrollment in the groups did not exceed five children. An experienced head teacher was assisted by a graduate student trainee in the Tufts' NIMH training program. All observations were recorded during the supervised activity period in the first hour of the school morning. They were first taken down in longhand and were dictated in detail within approximately two hours of the time of the original observations.

The System for Analyzing the Observations. The analysis of the observations was done by a social psychologist who had never visited the classrooms and who had never met the teachers or the children. The analyses were done from typescripts containing the verbatim record of the observer. The basic unit of analysis is the simple or complex English sentence. Compound sentences in the verbatim record have been separated into simple sentences for the purpose of analyzing the observations. Each unit (sentence) has been categorized in the following ways:

1. Teacher's actions.
2. Teacher's verbalizations:
 - a. To whom teacher talks.
 - b. About whom teacher talks.
3. Degree of responsibility toward a child which the teacher takes in actions and speech.

If a unit consists of an action or verbalization of someone other than the teacher it does not receive a coding. It is also important to note that the same unit may receive a joint coding (indicated by a slash line) for both 2a and 2b. This would occur if the teacher spoke to one child about another child or if she made a general comment to the group about a particular child. For example: "You know, [Bruce] Ann needs help." This sentence, which the teacher spoke to Bruce, about Ann, would receive a joint coding. Only verbalizations could receive a joint coding. Actions would always receive only a single coding.

1. Teacher's actions. In this category are recorded the actions of the teacher. Examples:

- Teacher is sitting with Charles.
- Teacher is helping Charles.
- Teacher puts cup away.
- Teacher moves between Bruce and Mary.
- Teacher is holding Mary.

2. Teacher's verbalizations:

a. *To whom teacher talks.* Under this heading are recorded the name or names of persons directly addressed, or else the word "group." The word group would occur if the entire group is directly addressed in a general announcement like, "It won't make so much noise," as the teacher is putting a mat down for someone to pound on. It may also occur if she is talking about a child but is not addressing her remarks directly to him, though she does talk loudly enough so that he might hear. For example: "Ann doesn't like noise." In this case the teacher spoke to the group.

b. *About whom teacher talks.* In the example, "Ann doesn't like noise," the

person talked about is Ann, and her name would be entered under this heading. The sentence, "Ann doesn't like noise," is an example of a unit (sentence) which would receive a joint coding because the teacher spoke to the group about Ann. The sentence, "You know, [Bruce] Ann needs help," is another example because the teacher is speaking to Bruce about Ann.

3. Degrees of responsibility toward a child which the teacher takes in actions and speech. We have constructed a six-step scale to indicate the degree of responsibility assumed by the teacher by her speech and actions for children's behavior, feelings and thoughts. We are primarily concerned with the frequency with which the categories occur, and whether these frequencies serve to differentiate between teachers. The following represents the criteria we use to code for the degrees of responsibility:

(1) Approaching, watching, sitting with a child. Category 1 indicates that the teacher contributes only her presence. It is assumed to be the type of interaction in which the teacher takes the least responsibility towards the child.

(2) Asking for information, answering questions with "yes," "no," or by supplying simple facts. To the question, "Where is the glass?", the answer, "In the cupboard." Such responses must be simple and must be in answer to a request initiated by the child. If a unit is coded 2, it is because the teacher does not add anything that is not implicit in the child's original question. The main burden of responsibility in the interaction remains with the child.

(3) Stating her own ideas and feelings, i.e. "I don't like noise." Providing materials, demonstrating materials, i.e. working with clay. Statements of fact such as, "You went to the zoo," "The

school's trains are green." If a unit is coded 3 it is because the teacher has taken some initiative to introduce an idea or add some information which the child did not specifically ask for. The ideas, etc., supplied by the teacher are available to the child, but no particular response is asked of him.

(4) Asking children to comply with her wishes. "Let's move over by Ann." "We're going to read now." "Take this stick." In this case a particular response to the ideas, etc., of the teacher is asked of the child.

(5) Working on the same materials the child has already begun to use. For example, working on a child's painting, or adding a block to his building. Washing his hands, adjusting his clothing, physically restraining or directing his movements. In this case the teacher intervenes to assume part or all of the responsibility for the non-verbal behavior the child has initiated or fails to initiate.

(6) Statements about a child's feelings or motives. "Bruce wants to get near." "Bruce got excited." "You will miss John." We have placed such statements

on the end of our scale of responsibility because the teacher makes assumptions about the child's motivations, wishes or private thoughts which are, of course, not directly observable. This, we assume, is even more intrusive than physical control of his movements.

The findings presented in this paper are based on four 10-minute observations: two for each of two experienced teachers of disturbed preschool children. These observations occurred late in the school year and on mornings when no "crisis" took place. They were chosen in order to get a "baseline" assessment when the teacher might be expected to be functioning in ways most typical of her usual behavior. We ask of the data the question, "Under these ordinary circumstances, do our teachers behave in the same ways or are there systematic differences that suggest different teaching styles?"

It can be seen from TABLE 1 that both teachers show high and consistent use of category 3 and category 4. Their individual consistencies are interesting to look at; e.g. Miss Green is low in the

Table 1
TOTAL CODINGS ON THE RESPONSIBILITY SCALE, BY CATEGORIES

CATEGORY	MISS GREEN						MISS BROWN					
	Obs. #1	%	Obs. #2	%	Total	%	Obs. #1	%	Obs. #2	%	Total	%
1.	2	(5)	1	(2)	3	(3)	9	(19)	3	(8)	12	(14)
2.	9	(20)	7	(15)	16	(18)	6	(13)	1	(3)	7	(8)
3.	22	(50)	21	(45)	43	(47)	19	(40)	24	(66)	43	(52)
4.	11	(25)	9	(19)	20	(22)	9	(19)	4	(11)	13	(16)
5.	0	(0)	8	(17)	17	(9)	0	(0)	0	(0)	0	(0)
6.	0	(0)	1	(2)	1	(1)	4	(9)	4	(11)	8	(10)
Totals	44		47		91 ^a		47		36		83 ^a	

^a There are more numbers here than units (sentences) because verbal units, if they receive joint codings, are entered twice on the responsibility scale.

use of categories 1 and 6, and operates in the middle of the range. She shows variable use of physical intervention, category 5. We do not have sufficient observations to draw conclusions about this.

Miss Brown's interventions are not centered in the middle of the range of responsibility in the way Miss Green's are. Dividing the range in half, 1-3 and 4-6, Miss Green emerges as taking slightly more responsibility than Miss Brown. However, Miss Brown makes consistent use of category 6 (10% of the time). She is also consistent in that category 5 is absent in her behavior in these observations.

The outstanding differences in style in these observations are in category 1 and category 6. In category 1 Miss Green averages 3%, while Miss Brown averages 14%. In category 6, Miss Green averages 1%, and Miss Brown averages 10%. Miss Green rarely makes statements about children's feelings and motives, whereas 10% of Miss Brown's verbalizations fall in this category. The average difference in their use of category 5, physical intervention, is 9%, but because Miss Green is not consistent in these observations, we cannot yet assume that physical intervention is a consistent feature of her style.

Joint Coding. It is interesting that a distinguishing aspect of the styles of these two teachers in these observations, is the difference in the number of times a joint coding is needed. The following are examples of joint codings:

EXAMPLES OF JOINT CODING

1. *Let's give Bruce a mat.* 4/

Here the coding before the slash indicates who was spoken to. In this case "let's" indicates it was the group.

2. *Ann doesn't like noise.* /6

Coding after the slash indicates Ann is mentioned in the third person. The blank before the slash indicates the group is not directly mentioned, though it is implied.

3. *Ann, you wait while Bruce is having his turn.* 4/2

Ann is spoken to, Bruce is spoken about.

Table 2
DISTRIBUTION OF UNITS

	MISS GREEN	MISS BROWN
Teacher's Actions	39	37
Teacher's Total Verbalizations	88 ^a	80 ^a
Joint Codings	12	28
Single Codings	76	52

^a The totals here will not correspond to the responsibility totals in Table 1 because the joint and single codings totals are based on units of verbal analysis (sentences). Totals in Table 1 reflect the fact that a unit which receives a joint coding would be entered more than once on the responsibility scale.

It can be seen that approximately one-third of the time (35%) that Miss Brown speaks, she speaks to someone about someone else. This is the case with Miss Green less than one-sixth (13%) of the time. In general, Miss Green seems to interact on a one-to-one basis with the children. In comparison, Miss Brown often includes other children in the group in her verbal communications. Seventy-five percent of her verbalizations about motives and feelings (category 6) receive joint codings. They are made to one child about another. For examples: "Bruce got excited." "Ann doesn't like noise." The impressions of the two styles which emerge are based primarily on the differences in the coding which are noted in TABLE 3.

Table 3
DIFFERENCE IN STYLES AS REVEALED
IN THE CODINGS

MISS GREEN	MISS BROWN
More single codings	More joint codings
Low 6	High 6
Low 1	High 1
Variable 5	No 5
More 4	Less 4

We are cautious in our willingness to draw conclusions from this data. The development of this coding system is in the pilot stage. We are aware of the methodological problems which exist in the accuracy of observation and transcription. Because of the small number of observations analyzed, tests of significance or reliability indices would not be worthwhile. We think the method shows promise of validity because a researcher who knew nothing of the children, teachers, or teaching "philosophies" could demonstrate the same aspects of differences in style that were apparent to experienced professional observers who knew the teachers and their work very well.

There is a certain mystique, particularly where young children or disturbed children are concerned, about the relationship of teacher and child which makes people hesitate to subject it to scrutiny. But only by doing so will we develop a common language which allows us to talk together about the issues. One must keep in mind that the Teacher Responsibility Scale has no direction on a "goodness" or "badness" continuum.

DISCUSSION

The two teachers described have gone about their jobs in different ways. They represent an interesting contrast in styles. One might infer that they per-

ceive their jobs differently, and that different "philosophies" may influence what they choose to attend to. In either case, the children probably learn to value what the teacher pays attention to.

We felt that a consideration of these two teaching styles, as they relate to two different philosophies and sets of goals, would help to bring out issues which seem to us to be important in planning such schools and training teachers for them. We propose to build a strong case for each style, and then to raise some more general questions which occur to us.

Miss Green's Style. From Miss Green's style the following goals may be inferred: the task of the therapeutic nursery school is to provide a corrective emotional experience with an adult teacher in whom the child can place his trust. The focus in the classroom is on the ongoing activity of the child. The teacher attempts to help him gain a sense of ease and competence in his handling of materials. The adult provides a helpful, nonpunitive model by working along with the child in a task-oriented way. This makes it possible for the child to progress toward a positive identification with the adult. He begins to value the kinds of activities available in the therapeutic nursery school which foreshadow those of the ordinary nursery school and kindergarten. According to this philosophy, the disturbed preschool child's primary need is for a corrective emotional experience with an adult in whom he can put his trust. He cannot yet be sufficiently interested in the other children for the group to be a meaningful focus. According to this philosophy he would not be ready to assimilate, in a useful way, the information Miss Brown would provide about feelings and moti-

vations. For this reason Miss Green builds her classroom climate around the one-to-one relationship focused on activities.

Miss Brown's Style. In contrast, Miss Brown might espouse the following goals: Children need to learn (1) that they have legitimate needs, and that these needs can be legitimately met; (2) that they can have an effect on other people and materials; (3) that they can be reflective about their own feelings and behavior; (4) that they can elaborate their ideas and actions when they interact with others and with materials.

Miss Brown sees relevance in the relationships among the children in her classroom. Motives, feelings, materials, behavior, and their interrelationships are important, and the teacher attempts to provide links for the child in these areas. When a child is not verbally interacting with her, she is still physically present and interested in him. She tells him this by offering her presence, and by often speaking out loud about what she observes a child doing or what she thinks he may be saying. In this way she attempts to help him gain some distance from himself. She sometimes adds to, or replaces, his actions and feelings with words, and encourages him to consider alternatives.

Miss Green, on the other hand, sets up a series of individually focused relationships. When not confronted verbally and directly, she is attending to another child. She places less emphasis on bridging the gap between children, their behavior, feelings, and activities. An emphasis on individual children is a narrower focus than that of Miss Brown. On the other hand, a preoccupation with statements regarding children's motivation suggests an ability no human

being really has: i.e., an ability to read the mind of another. By venturing into the realm of interrelationships and motivations, Miss Brown opens up another spectrum of possibilities, but that is not without risks.

We have tried to build a strong justification for each style. This analysis does not exclude the possibility of other styles, with their underlying philosophies.

Certain questions can be raised:

1. Is it more important for the disturbed child in the therapeutic nursery school to have a corrective emotional experience with respect to the adult teacher or with other children?

2. Can the kind of information Miss Brown provides about feelings and motivations of the children be assimilated in a meaningful way by these children?

3. Are the children sufficiently interested in each other for a meaningful group to evolve?

There are also questions about the consistency of a particular style with the personality of a teacher. Should the teacher structure the situation in a manner which fits with her own needs and capacities because this is the way in which she functions optimally? Perhaps there are children who would profit more from one style than from another. Observation in normal nursery schools suggests that as children grow older relationships to each other become more important than the one-to-one relationship to the teacher. This may indicate that certain aspects of teacher style could be matched with certain developmental stages in children.

We wonder if a training program should work to develop a teacher's style consistent with a particular philosophy of therapeutic nursery school education.

What are the pitfalls in attempting to change a teacher's style too fast, or too much?

These questions remain to be answered. Our attempt has thus far been instructive for us as trainers and supervisors. We are closer to finding effective ways of helping our trainees to learn about teaching. We hope to be able to find more effective ways of assessing their strengths and weaknesses, and individualizing their programs. We are not searching for one "right" way to teach. We hope that more objective ways of describing differences in teachers will foster a more active dialogue about teaching.

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SOME CORRELATES OF EARLY-DETECTED EMOTIONAL DYSFUNCTION IN THE SCHOOLS

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Clinical judgments of early-detected emotional dysfunction were studied in relation to a battery of adjustment, parent attitude, sociometric, and achievement measures given at the end of third grade. The ratings, made on a 7-point health-pathology scale, correlated in meaningful ways with the criterion variables attesting to the sensitivity of the early detection procedure.

Perhaps the most basic justification underlying development of procedures for early detection and early secondary prevention of emotional disorder is the assumption that manifest and latent childhood dysfunction predict reliably to future, sometimes more serious, maladjustment. Though this assumption has not always been clearly upheld,^{12, 16} most relevant empirical data supports such a view.^{2-4, 6, 14, 15, 18, 21, 22, 24, 25} The consistency of the latter findings underscores the need to buttress early detection procedures, since identification is an

essential component of a broader early secondary prevention model.

For nearly a decade a group of investigators in Rochester, New York have been concerned with the development of preventively oriented school mental health programs.^{8, 9, 22} A central element of this work has been the early detection of primary graders with manifest or incipient emotional dysfunction. This identification process has been based on social work interviews with mothers of first-grade children, psychological evaluations using brief screening procedures,

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teachers' impressions of children, and classroom observations. Using such data, an arbitrary, dichotomous clinical judgment was rendered for each child at the end of the first school year by the school psychologist and social worker. Children evidencing manifest dysfunction or those who gave evidence of its incipience were called "Red Tag" (RT), while youngsters with neither current nor predicted future difficulties have been called "Non-Red-Tag" (NRT).

Comparison of RT vs. NRT children for two independent samples^{8,9} on an array of evaluation measures indicated that the RTs were significantly inferior on 4 of 12 and 14 of 20 criterion indices, respectively, by the end of the third school year. Since the criterion battery included measures of performance and achievement; sociometric status; self, peer, and teacher rating; and adjustment; the observed RT deficit may be viewed as a generalized one. Both samples have been followed up in seventh grade to determine the stability of the initial deficit over time. Generally speaking, RTs continued to be negatively differentiable from their NRT peers on a variety of achievement, behavioral, and adjustment measures.²⁵ For the two-year groups 45 of 51 and 40 of 44 criterion indices directionally favored the NRTs, with 10 and 13 statistically significant differences, respectively.

Although the preceding findings indicated the considerable heuristic value of the RT judgment, its scientific base remained less communicable. This disparity prompted a further study¹ designed to objectify the red-tagging procedure and to identify more specifically the sources of that clinical judgment. To these ends, judges were trained to evaluate the protocols of the social worker's

interview with mothers of first grade children (the prime source of variance in the prior clinical judgment) along 37 dimensions considered relevant to this adjustment process, as well as to make a single overall adjustment rating along a 7-point continuum. These judgments were reliably rendered and there was a high degree of overlap (85%) between the summed or global ratings and the dichotomous RT-NRT clinical judgment. Phrased otherwise, we had established a continuous, reliable, and communicable health-pathology rating.

The central aim of the present study is to explore the sensitivity of this recently developed rating. Specifically, we are concerned with the relation between an early-detection index, in this case a continuous-scale judgment of health-pathology, rendered at the first grade level by professional specialists, and a battery of 3rd grade school record, achievement, performance, adjustment, and sociometric measures. Since it was our assumption that emotional factors are highly influential determinants of all aspects of the child's school functioning, we expected to find substantial relations between the independent index and the array of dependent criterion measures.

METHOD

Subjects. The entire third grade (30 boys and 29 girls) of a relatively small elementary school in Rochester, New York comprised the sample for this study. The school, though predominantly upper-lower and lower-middle class socioeconomically, served a large geographic area and was relatively heterogeneous with respect to SES makeup. Ethnically, it accurately reflected the city at large with some underweighting of Negro and Jewish children. All young-

sters had been given a dichotomous RT-NRT classification at the end of the first school year after completion of the screening procedures described above. Additionally, these 59 youngsters had participated in an early secondary prevention program involving, particularly, the articulation of a consultative role for school mental health professionals vis-à-vis teachers and other school personnel, and the establishment of an interventive model utilizing nonprofessionals (housewives and college students) in committed human relationships with children referred for special help. The effectiveness of these types of preventive programs for the group as a whole^{8,9} and of the specific interventive programs for the child with earlier detected disorder^{10, 22, 28} have been reported elsewhere.

Procedure. Ratings for each child, using the 7-point health-pathology continuum were rendered by the psychologist and social worker at the end of the third school year based on the social work interview, psychological evaluation, and teacher observations. Although the dichotomous RT-NRT classifications were not specifically utilized in this process—nor were they known to the teachers—they could conceivably have been recalled by the raters. Moreover, some youngsters had been specifically discussed on occasion by the raters. Thus, the two judgments were by no means independent and, given these circumstances, the obtained interrater reliability of .87 is not especially high. There were five cases in which the judges differed by two or more scale points in their initial judgment. These were discussed and re-rated (after the reliability estimate had been obtained) to yield the final scores. For each subject the ratings

of the two judges were then summed, yielding a theoretical range of scores from 2–14. In actuality, these summed ratings were distributed normally, with a mean and mode of eight.

A criterion battery, including adjustment, parent attitude, sociometric, and achievement measures, was administered to all Ss at the end of the third school year.

INSTRUMENTS

Children's Manifest Anxiety Scale (CMAS): This instrument includes a 42-item anxiety scale and an 11-item lie scale,⁵ and yields scores for manifest anxiety and for S's tendency to view himself favorably.

Thinking About Yourself (TAY): This is a measure of self-ideal discrepancy.² The S is asked to indicate both how much he is like a child being described on a series of concrete attributes, and how much he would like to resemble that child.

Ottawa: This is a school behavior survey sampling 20 maladaptive classroom behaviors.¹⁷ Teachers indicate whether or not specific maladaptive behaviors (e.g. "steals," "runs around room," "plays alone") are typical of each child by checking either "yes" or "no." A score is obtained by summing the number of items checked "yes."

Teacher's Checklist (TCL): This instrument consists of two scales, each requiring teachers' ratings of children.⁸ First, 25 examples of maladaptive behaviors (e.g. "is disobedient", "disrupts class") are listed and the teacher checks those that describe a given child. For each item so checked a 3-point intensity rating is also made (i.e. "shows mildly," "shows moderately," "shows very strongly"). A second score is obtained

from a 34-item adjective checklist (ACL) including 17 positive and 17 negative characteristics (e.g. "rude," "sad," "neat," "kind"). For each item the teacher indicates whether or not it "describes child very well," "applies somewhat to child," or "does not apply to child."

Parent Attitude Test (PAT): This measure includes four questionnaires tapping parents' perceptions of their child's attitudes and behaviors.⁷ On the first 4-item scale the parent rates his child's attitudes to school. On a similar 7-item scale the child's attitudes to the home are rated. For both of these scales, ratings are made on a 5-point Likert scale. High scores indicate parent perception of negative attitudes in the child. Separate school, home, and combined scores are obtained.

The third subscale is an adjective checklist (ACL) with the same 34 items rated by teachers (above). The 17 positive and 17 negative adjectives are scored as indicated for the prior measure.

Last, a list of 25 items is presented, each reflecting a specific behavior problem (e.g. eating trouble, stomach trouble, temper tantrums). The parent indicates which behaviors his child has exhibited during the past month and to what degree—"very mildly" to "very strongly"—along a 4-point scale.

Class Play. This instrument describes hypothetical roles, half positive and half negative, in a play that a class might present.² In Part I, the S selects classmates whom he considers suitable for each role. In Part II, he indicates which of a second series of positive and negative roles he would like to play and which he would be chosen for by his teachers and peers. Seven scores are obtained from this instrument, indicating the percentage and

number of negative choices of the subject made by his peers, the total number of choices (positive and negative) by peers, and the percentage and number of negative self-choices. A difference score is also obtained, indicating the discrepancy between the percentage of self-selected negative roles and negative roles for which the child has been selected.

Achievement Measures. In addition to obtaining Otis IQ scores and averaging each S's report-card grades for the third school year, a measure of over- and underachievement was utilized. Both IQ and GPA were converted to standard scores and the former subtracted from the latter. With the addition of a constant to eliminate negative scores, a large discrepancy score reflects overachievement, whereas a small one reflects underachievement.

Several standard achievement test scores were obtained from each S's school record. These were the Pupil Evaluation Program (PEP),¹⁸ math and reading tests, the Metropolitan reading and numbers tests (grade 3), and the SRA reading and vocabulary tests (grades 1-3).

RESULTS AND DISCUSSION

Pearson r 's were computed between RT ratings and scores on each of 37 criterion variables, separately by sex and for the total sample. The data are presented according to an arbitrary classification of the criterion variables as: adjustment, parent attitude, sociometric, or achievement measures. TABLE 1 reports r 's between the RT ratings and the 37 dependent measures.

The RT estimate, essentially a summed clinical judgment of health-pathology based on multiple sources of evidence, correlated strongly with all three teacher

Table 1
RELATION OF RED TAG RATINGS TO CRITERION MEASURES

VARIABLE	N ^a	r	p
ADJUSTMENT MEASURES			
CMAS-Anxiety	59	-.28	.05
CMAS-Lie	59	.07	NS
TAY	59	-.10	NS
Ottawa	56	-.71	.01
TCL-Behavior	57	-.64	.01
TCL-ACL	56	-.69	.01
PARENT ATTITUDES			
School	37	-.61	.01
Home	37	-.36	.05
School + Home	37	-.53	.01
Behavior	37	-.24	NS
ACL	37	-.49	.01
SOCIOMETRIC MEASURES			
% Neg. Choices (peers) I	59	-.43	.01
# Neg. Even Choices (peers) I	59	-.24	NS
# Pos. Choices (peers) I	59	.41	.01
Total # Choices (peers) I	59	.16	NS
% Neg. Self-Percept.: II	59	-.26	.05
# Neg. Even Choices (self) II	59	-.31	.05
CP-D Score	59	-.22	NS
ACHIEVEMENT MEASURES			
Σ Grades	59	.59	.01
Otis	54	.41	.01
Ach.-Apt.	54	.14	NS
PEP			
Problem-Solving	59	.49	.01
Concepts	59	.50	.01
Total (Math)	59	.48	.01
Reading Comp.	59	.60	.01
Total (Read.)	59	.58	.01
Metro			
Reading	38	.43	.01
No. S.	38	.52	.01
Total	38	.53	.01
SRA-1st Grade			
Verb. Pict.	42	.48	.01
Comp.	42	.46	.01
Vocab.	42	.37	.01
Lang. Percept.	42	-.14	NS
SRA-2nd Grade			
Read. Comp.	50	.54	.01
Vocab.	50	.53	.01
SRA-3rd Grade			
Reading Comp.	59	.50	.01
Vocab.	59	.59	.01

^a Ns vary for different measures due to factors such as absence of child on testing day or failure of parent to return forms.

estimates of adjustment, and weakly but significantly with the anxiety scale. Similarly, there was a substantial correlation between this judgment and all but one of the parent measures. Not surprisingly, the highest r involving the cluster of parent indices was with perception of *school* attitudes ($r = -.61$). While there were moderate r 's between RT rating and several sociometric measures, these were less robust than the r 's with adjustment variables. In fact, only four of the seven r 's in this group were significant, the highest of these (% Negative Choices on Part I of the Class Play) being $-.43$. The nub of the sociometric findings is that youngsters who were "identified early" by the professional team were selected for negative roles more often both by peers and by themselves.

Finally, consistent and significant relationships with r 's ranging primarily from .40-.60 were found between RT and 17 of the 19 achievement measures used in this study. RT rating is thus related to poorer achievement at all grade levels and in all content areas (reading, arithmetic, and language skills) examined. This finding is consonant with those reported in the literature by other investigators.^{9, 11, 18-20}

In sum then, the continuous RT judgment of early-detected pathology relates sensitively and substantially to a number of adjustment, parent-attitude, sociometric, and achievement measures. Among these significant relations the strongest are with teacher estimates of adjustment, the weakest and most vari-

able with the sociometric judgments, and the most consistent with indices of school achievement.* Knowing the child's status on the health-pathology dimension, reflected in the RT judgment, thus provides meaningful predictive cues about his functioning along a number of highly relevant dimensions in the school setting.

The r 's between RT and the criterion measures computed separately by sex are not significantly different from each other, overall. Though it might be tempting to drop the matter with that statement, it would be misleading to do so. There is a provocative pattern throughout the data of more robust r 's, involving RT and criterion variables, for girls in comparison to boys. Only one such sex difference is statistically significant, that for the r between RT-PAT (Home), where $r_m = -.02$; $r_f = -.66$, $pr_m - r_f = .01$. On the other hand, for girls 29 of 37 zero-order r 's with criterion measures are significant; for boys the comparable figure is only 17. Moreover, directionally higher r 's for girls are found in 27 of the 37 pairs of r 's computed. Although such a distribution yields a $\chi^2 = 7.81$ ($p .02$), it is difficult to evaluate it precisely because of the indeterminate nonindependence of individual r 's from others.

Nevertheless, the foregoing pattern is sufficiently striking to merit comment. There is the distinct possibility of significant differences between sexes in RT-criterion r 's, which is perhaps attenuated in the present data through diminution of N in the separate sex analyses.

Speaking substantively, what is sug-

* Because of an r of .41 ($p = .01$) between RT and IQ, we were concerned that the relation between RT and other dependent measures might be mediated by IQ. We therefore computed partial r 's (ruling out IQ) between RT and 17 criterion measures strongly correlated with IQ. The average shrinkage in r was .06, and in no case did an initially significant RT-criterion r now fall short of significant. Thus the potentially distortive effects of IQ were, in fact, trivial.

gested (but not statistically demonstrated) by the present findings is that cues of ineffective functioning in the young girl are quickly seized upon and utilized by professional (or other) judges in making inferences about adjustment-maladjustment. For the young boy, however, there seems to be more tolerance and leeway, and single instances or signs of malfunction are more likely to be isolated from a global judgment about adjustment. Possibly this is the case because girls emit fewer cues of dysfunction in general and therefore, when one becomes evident, it is magnified. Perhaps when a boy acts out, fails exams, behaves atypically, or doesn't "toe the mark," observers can "accept" or "rationalize" the behavior as culturally tolerable. However, when these same things happen to a girl, she is more likely to be "marked" by those who come in contact with her, including professional mental health specialists. The foregoing "free associations" are less generalizations from our data than they are suggestions for further work, growing out of the pattern of present findings.

OVERVIEW

Broad overview of the present findings leads to these conclusions: The expanded 7-point RT judgment framework is a sensitive, discriminating, screening device for early detection of manifest or incipient dysfunction. RT ratings of third graders relate in logical and consistent ways to measures of adjustment, parent attitudes, sociometric status, and achievement. Inherent in these relations is a reasonable consistency of perception and evaluation embracing mental health professionals, teachers, parents, and child-peers.

Though the findings are far from clearcut, the present data suggest that the bases for judgment of school dysfunction may be different for boys and girls. All indicants of ineffectiveness are likely to carry weight in estimating adjustment-maladjustment for girls, whereas for boys this judgment may both be more complicated and based on greater tolerance for any particular sign of ineffectiveness. The latter statements are speculative and must be explored in studies using larger *Ns* than were available in the present investigation.

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TWO STUDIES OF CHILDHOOD DREAMING

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The technique of dream retrieval by nocturnal awakening during periods of rapid eye movement (REM) sleep was employed with preschoolers and with both normal and emotionally disturbed male adolescents. Dreams of children at both ages were generally directly related to their waking lives, but personality pathology was associated with more vivid and unrealistic dreaming.

The discovery of electrophysiological correlates* of vivid dreams has made it possible to awaken subjects while they experience such dreams. Since episodes of rapid eye movement (REM) sleep recur periodically at 60-100 min. intervals, awakenings can be made several times a night. Generally, about 80-90% of REM-sleep awakenings produce dream recall in young adult subjects.⁵

Subjects in electrophysiological dream studies have usually been young adults.

Several studies with limited numbers of subjects and awakenings have noted that children can also recall dreams on awakenings from REM sleep, but their authors fail to elaborate on the nature of the dreams that were collected.^{19, 20, 26} The most extensive electrophysiological study of childhood dream content has been that of Foulkes et al.¹⁰

These authors studied 32 boys aged 6 to 12 for two nights each, and obtained dream recall on 72% of 249 REM-sleep awakenings. Both ratings and content

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* EEG sleep stage 1, rapid eye movements (REMs), suppressed neck and chin electromyograms (EMGs).

analyses of the boys' dreams suggested that they were generally realistic in characterization (e.g., parents, siblings, male peers), setting, and plots (e.g., everyday recreational activities) and that they were relatively free of bizarre symbolism and unpleasant affect or impulse. On the basis of subsequent case studies of four of these boys,⁸ it was argued that the child's dreams may become bizarre and unpleasant only to the degree that he is experiencing difficulties in his waking adjustment.

These results do not agree with much clinical lore on the nature of childhood dreaming. Calvin Hall, for instance, states that "What little knowledge we have of children's dreams suggests that their dreams are much more complex and much more dreadful than has previously been thought."¹⁰ There are several possible explanations of the discrepancy of the "latency" child they studied and statement. The "dreadful" properties of the child's dream may be seriously overestimated from daytime recall, in which only those dreams sufficiently nightmarish to produce spontaneous arousal

are well-recalled, and from studies of children whose unrepresentative emotional disturbance is in fact associated with particularly vivid and frightening dreams.

It is also possible, however, that the relatively affect-free quality and the realism of the dreams collected by Foulkes et al. reflect peculiar aspects of the "latency" child they studied and are not representative of younger or older children. The two studies to be reported here investigate this latter alternative: laboratory dreams were collected from preschoolers and from adolescent males to determine whether they differed markedly from those of 6- to 12-year-old boys. In addition, the adolescent study included both normal and emotionally disturbed boys in an attempt to confirm the hypothesis that personality pathology in children is correlated with more unreal and unpleasant dreams. Confirmation of the hypothesis would point to sampling biases in clinical dream studies that may lead to an overestimation of the bizarreness and affect of the normal child's dream.

STUDY ONE: DREAMS OF THE PRESCHOOLER

SUBJECTS

Six boys aged 4-1 to 5-6 (median: 4-6) and six girls aged 3-0 to 5-0 (median: 4-4) were recruited through advertisements in the campus newspaper and from acquaintances of the experimenters. Nine of the 12 children were aged between 4-0 and 5-0, inclusive. Subjects were paid for their services. Their fathers represented a wide range of occupations, but all came from the broad middle stratum of society. One subject (#13) had attended nursery school.

METHOD

Subjects slept for two nonconsecutive nights in the laboratory. One or both parents generally accompanied the child to the laboratory and remained until the child fell asleep, sometimes staying for the entire night. Two EEG electrode placements (generally parietal and prefrontal) were made upon all subjects, and electrodes were placed lateral to the eyes of each subject for recording EOGs (electro-oculograms). All-night recordings were taken on an Offner Type R Dynograph with four channels

per subject, generally comprising a monopolar parietal EEG (with neutral reference electrodes over the mastoid process), a bipolar EEG, and two monopolar (right, left) EOGs.

Identification of episodes of REM sleep proved no more difficult for these young subjects than for young-adults. Awakenings were made at variable intervals after the onset of REMs (range: 2-33 min.; median: 9 min.). Seven awakenings were obtained over the course of the two nights for each subject; for 10 of 12 subjects, there were three awakenings on Night 1 and four on Night 2. Awakenings generally were made in consecutive REM periods only when it appeared that the awakening schedule could not otherwise be fulfilled. In other cases, subjects were allowed several uninterrupted REM periods throughout the night.

Nocturnal interviews were conducted at the subject's bedside (except for Subject 1, who was awakened over an intercom unit) and were tape-recorded for later transcription. Upon establishing effective contact with the subject, the interviewer asked him if he could remember a dream. If the answer was yes, the interviewer asked what it was about. If the answer was no, the subject was asked to think for a moment or so to see if he could remember anything; if not, he was allowed to return to sleep. When a spontaneous report was given, the interviewer asked a minimal number of unstandardized questions to clarify characters, settings, and dream activities. Where identifications of persons or places were still unclear, parents were later questioned to elucidate dream elements. The nature of the subject population did not favor a rigidly formal interview format. Interviews were con-

ducted (except for Subject 4, who was interviewed by the senior author) by an experimental assistant without any particular theoretical interest in the nature of the reports she collected. We did allow a parent to conduct some of the later interviews of two subjects (6, 9) who had not recalled any dreams, but these parental interviews yielded no dream reports.

Following their nights in the laboratory, subjects were administered three sections of Laurendeau and Pinard's²¹ tests of precausal thinking (Dream, Life, Night) and the Blacky Test.⁸ Parents were mailed two copies of the Traditional Family Ideology Scale²² with instructions to complete them independently. Replies were received from all 24 parents.

RESULTS

Adaptation to Laboratory and Sleep Patterns. Mean time to sleep onset after lights out was 22 min. (median 14.5 min., range 0-56 min.). This is identical to the figure previously reported for 6-8 year old boys.¹⁰ On more than 50% of 60 experimental awakenings followed by another awakening on the same night, sleep (EEG stage 2) onset was achieved in 6 min. or less following termination of the dream interview; in only 4 instances, all on Night 1, did latency to sleep onset under these circumstances exceed 60 min. These data establish that subjects experienced no great difficulty in adapting to sleeping under laboratory conditions and to the interruption of their sleep by experimental awakenings.

Since sleep was interrupted at varying times of the night and following variable durations of REM sleep, meaningful figures on the proportion of total

sleep time spent in REM sleep cannot be reported. Data are available, however, on a related measure of a subject's propensity to REM sleep: latency from sleep onset to his first episode of REM sleep. In a two-night study with young adults, the mean latency has been reported as 91 min.,²⁴ while our two-night study of 6-8 year old and 10-12 year old boys yielded mean latencies of 170 and 153 min., respectively.¹⁰ In the present study, mean sleep latency to REM onset was 129 min., with a Night 1 mean of 144 min. and a Night 2 mean of 113 min. The adaptation effect was significant ($T=13$, $p=.025$, 1-tail²⁹).

These various figures on sleep latency to initial REM onset, including the briefer latency for the preschooler than for the older child and preadolescent, agree with data reported by Fisher⁷ on the other measure of REM propensity, the percentage of undisturbed sleep spent in REM sleep. As Fisher points out, however, present REM-percent figures during childhood are based on limited n's. Observations in the present study suggest considerable individual differences in REM sleep phenomena during early childhood, and thus the need for cautious interpretations of presently available data. Subjects' Night 1 and Night 2 latencies to REM onset were fairly consistent with one another ($\rho=.67$, $p=.05$, 1-tail^{*}) but highly variable across subjects. Subject 5 had a mean two-night latency to REM onset of 59.5 min.; the comparable figure for subject 11 was 201 min. Sex differences were negligible and not significant.

Recall. Some item of substantive content was reported on 37 of the 84 awakenings (44%). The mean substan-

tive word count for these 37 reports was 21.9. The median individual subject recall value was recall on 3.5 of 7 awakenings (50%). Subject variability was extensive (see TABLE 1). Neither age nor sex discriminated total non-recallers from subjects who recalled at least one dream, although all three subjects who reported apparent dreams on every awakening were girls.

Dream Content. TABLE 1 presents, in highly abbreviated form, some indication of the most common kind of dream that was collected from each of our eight recallers. Subject 3's dream reports were very fragmentary (snakes; streetlights [a probable incorporation of a light that the experimenter usually turned on only after his call but that on this occasion came on before the awakening]; the tape recorder and chair next to his bed; a "soldier man"). Subject 4's dreams were of: riding his tricycle; flying a kite; riding a horse; and driving a car. Subject 5's dreams were of: taking turns with her siblings riding their horse; going to school and a postman sending postcards to people; her brother riding his horse in a pasture; her grandfather looking for her mother to give her a pair of sunglasses; playing with her siblings in the backyard; a train with white signs on it; splashing in a swimming pool with her siblings. Subject 7 dreamed of sailing a boat, of his brothers building a boat and his sailing in it, and of caterpillars crawling on his sister's leg (this was also a probable incorporation of a sleep stimulus, and is discussed further below). Subject 8, like Subject 3, apparently experienced a fragmentary, static visual image (mother's desk) but she also reported

* All correlations subsequently reported for Study 1 are also Spearman rank-order coefficients.

Table I
DREAM RECALL AND DREAM CONTENT

Subject	Sex	Age	Recall	Mean Dream Word Count	Most Common Dream Theme and Incidence
1	M	4-6	14%	17.0	[Only dream was of washing his hands in the bathroom]
3	M	4-6	57%	7.0	Fragmentary, apparently static percepts (n=4)
4	M	4-1	57%	17.8	Playing in realistic settings (n=3)
5	F	5-0	100%	25.9	Playing with siblings or siblings playing in realistic settings (n=4)
6	M	4-6	0%	—	—
7	M	5-6	43%	53.3	Playing (sailing boats) (n=2)
8	F	4-0	57%	35.0	Fragmentary static and/or dissociated percepts (n=3)
9	M	5-4	0%	—	—
10	F	3-0	0%	—	—
11	F	4-1	100%	15.6	Animals eating (n=4)
12	F	4-9	0%	—	—
13	F	4-6	100%	14.9	Animals (n=7) (with milk as dream element, n=3)

dissociated static images on two awakenings (red apples and people walking; a cowboy juxtaposed with her parents talking to one another) and one dream episode (a friend pressing leaves at her babysitter's house).

Dreams of Subjects 11 and 13 were different in character from those reported above in that they were almost entirely populated with animals. Subject 11 reported dreams of: a horse, a teddybear eating cereal, a lamb eating ham; a green cow eating French toast; a cow eating French fries; a horse eating; a little horse; a kangaroo walking in the grass; and a toy duck and airplane. Subject 13 reported dreaming of: a man milking a cow; a farmer milking a chicken; a lamb drinking milk; a teddybear swimming; a horse trying to get into a barn because he was cold; a lamb knocking at a locked door; and a rattlesnake "getting" a 6-year-old boy.

In general, subjects' dreams, with the exception of those of Subject 11, were

realistic in characterization, setting, and plot or bore some demonstrable relationship to their behavior in the period immediately preceding their laboratory service. This was particularly true of Subjects 4, 5, and 8, whose reports we believed, on the basis of subjects' attitudes to laboratory service and of the style in which reports were delivered on nocturnal interviews, to be least likely to be confabulatory. Subject 5's dreams, for instance, all contained direct or indirect references to familiar persons and/or recent events. She lived on a ranch and she and her siblings often did ride horses. Her dream of going to school was probably related to the fact that the subject lived 200 miles from the laboratory, and had told her siblings with some pride as she had left home that *she* was "going to college." Her dream of a train came one night after her aunt had taken her to the local depot to see a passenger train, of which there were none in her hometown area.

Even Subject 13's animal dreams proved partially explicable in terms of recent events in her waking life: her mother reported that the subject was extremely interested in a neighbor who was nursing her baby. The girl had asked her mother if the woman had to drink milk to give milk, and the mother had replied that you just had to eat any kind of food, as, for example, a cow eats grass to give milk. Subject 13's only sibling was a 6-year-old brother. She was quite definite that the rattlesnake in one of her dreams was "getting a 6-year-old boy."

The case of Subject 13 accentuates a point that may be made with respect to most of the dreams of the other subjects (again except Subject 11): although generally realistic or plausible, most preschoolers' dreams are not mere memories or re-creations but are "dreams," i.e. they are worked-over and reconstructed bits of past experience. The general conclusion still holds, however, that the preschoolers' dreams are more often realistic than bizarre, usually directly related to contemporary events in the subject's life, and neither particularly more complex nor dreadful than the relatively benign dreams of pre-adolescent boys. Play topics overshadowed any other single class of manifest content.

The authors believe that Subject 11 is not a genuine exception to the trends observed above. The interviewer formed the definite impression, from the manner in which this subject's nocturnal reports were given, that she was confabulating. In addition, the subject's mother indicated that the subject had told her, *before* Night 1, that she was going to dream of horses. She had two such re-

ports on Night 1. Several other mothers said that their children also anticipated the things of which they would dream in the laboratory, but those anticipations were invariably incorrect. Furthermore, the subject confabulated to the experimenters about the number of her siblings, etc. in informal conversation in the laboratory. No comparable episodes of demonstrable confabulation were observed for any other subject. This subject's score on the Dream subtest, as will be noted below, indicated a low level of dream comprehension found incompatible in other subjects with any dream recall. With the exclusion of Subject 11, dream recall for the remaining subjects would drop to 39% (recall on 30 of 77 awakenings).

Test Results. Statistical tests of psychometric data will omit Subject 11 for reasons noted above.

Maternal and paternal TFI scores intercorrelated only .14 (ns). The fathers' TFI scores correlated $-.74$ with their children's dream recall ($p = .02$, 2-tail). Mothers' TFI scores correlated only $-.08$ with these dream scores. The significant paternal-child correlation has two interesting aspects. First, it is negative. With a theory stressing the complementarity, rather than the continuity, of dream experience and waking experience, it might have been predicted that the child with an authoritarian parent would be under more strict impulse control in wakefulness and hence have more vivid and memorable displacements of these impulses to sleep. Second, the parental-child correlation is large and significant only for the father. This fact also suggests a continuity of waking and sleeping fantasy, for

several studies have observed that authoritarian parents, especially fathers, have children with relatively undeveloped waking achievement imagery.⁴ Similarly, Marshall²³ found that dramatic or make-believe, but not realistic, uses of language and hostility in play with peers at preschool tended to be related to paternal, but not maternal, Parental Attitude Research Instrument scores.

The results of the Laurendeau and Pinard tests^{*} suggested that adequacy of conceptual development, particularly with respect to dream phenomena, is related to the ability to report dreams in the laboratory. A certain level of comprehension of the dream (the level of mitigated realism) would seem to be a necessary but not a sufficient condition for laboratory dream recall.

A scale was devised, following the findings of Amen's² study of pre-

schoolers' responses to projective stimuli, to assess subjects' general level of apperceptive response to the Blacky pictures (Descriptive Ability Scale). Amen found that static description or identification reached its peak among 2-year-olds, description in terms of overt activity of characters among 3- and 4-year-olds, and description modified with imputed psychological states or motives among 4-year-olds. DAS scores^{**} on the Blacky pictures correlated .61 with laboratory recall ($p = .05$, 1-tail). Moreover, Subject 5, whose ability to report mentation from sleep was successfully tested later, ranked highest on descriptive ability, while Subjects 3 and 8, whose modal dream content consisted of fragmentary or non-coherent visual percepts, had the lowest descriptive ability scores of any of the recalling subjects. This simple scale of waking descriptive ability, then, demon-

* The Laurendeau and Pinard tests²¹ were scored independently by two of the authors. Initial agreement of classification was present for 83.3% of subjects on the Dream and Night subtests and for 75.0% of subjects on the Life subtest. A single reconciliation score was easily achieved for all but one discrepant case, which was resolved by a coin toss. Composite scores (a rank of mean subtest rankings) representing the children's overall performances on the three Laurendeau and Pinard subtests and their scores for the Dream subtest alone were then correlated with their dream recall. Neither rho was significant, although both were positive. The larger value observed was between ranking on the Dream subtest and laboratory dream recall (.36). There is some suggestion, then, that adequacy of conceptual development, particularly with respect to dream phenomena, is related to the ability to report dreams in the laboratory.

The observed relationship is obviously far from perfect as the relatively low and nonsignificant correlation indicates. However, 7 of 9 subjects scoring at the level of at least mitigated realism (Laurendeau and Pinard's classes 2A, 2B, and 2C; the dream at least partly subjective in character) recalled dreams, while only 1 of 3 subjects below this level had any recall. This subject with a relatively inadequate conception of the dream, but apparently perfect dream recall, was Subject 11. If we are justified in excluding her as a probable confabulator, the data suggest that a certain level of comprehension of the dream (the level of mitigated realism) is a necessary but not a sufficient condition for laboratory dream recall.

** In analysis of the Blacky stories, one category (no response or irrelevant response) was added as the low point of this scale, and descriptions of overt activity were subdivided into simple ("Blacky is walking to the people") and compound ("One day when Blacky was watching the family, the papa was patting his hand and the mama licking his face"). This yielded a 5-point (0-4) scale for the analysis of each story. Mean score values for each subject were then computed independently by each of two raters, with an interjudge reliability of .92. The mean subject values of the two judges were then averaged to yield a single DAS score.

strated an impressive capacity to predict (and perhaps validate) subjects' verbal performance on awakenings from REM sleep.

Stimulus Incorporation Trials. Subject 11's case highlights a general problem in working with young children: what degree of credibility is to be attached to their verbal reports? Although this may appear incapable of resolution in dealing with reports of something as private as the dream, there are several ways of testing whether subjects can report material immediately following sleep that actually occurred during sleep. Within REM sleep, one possibility is the correlation of preawakening eye movement patterns with the nature of postawakening reports.²⁷ Another is the correlation of the report with a stimulus applied and terminated during sleep.⁶

As noted above, Subject 3 had one presumably incorporative dream of a light stimulus applied before he was awakened. Subject 7's caterpillar dream probably falls in the same class. The experimenters were startled, 4 min. after his REM onset, to hear the subject cry out loudly in apparent terror. He did not awaken, however, so an experimental awakening was initiated. The interviewer immediately noticed as she entered the room that the subject's worm-like electrode chain was lying in a strange position across the back of his neck. His dream was that he was in the family car and that a brother put crawly "caterpillar worms" on his sister's leg as they were driving to school to pick up another brother. These two episodes suggested systematic attempts at influencing subjects' dreams through stimulus application during REM sleep. Negative results, of course, would be inconclusive: subjects' dreams, accurately reported,

simply may not have incorporated the stimulus. Positive results, on the other hand, would establish that the subject could, at least on some occasions, report sleep mentation upon experimental awakenings from REM sleep.

Subject 11 refused to return to the laboratory for this further testing. Subjects 4, 5, 8, and 13 did return to the laboratory for one night of stimulus applications during REM sleep. Four stimuli were employed: drops of water from an ear syringe; puffs of air from the same syringe; an emeryboard rubbed across the subject's skin; and a puff of cotton lightly applied to the subject's skin.

Subjects 4, 8, and 13 had much the same kind of dreams as before. No obvious incorporations were noted. Subject 5, on the other hand, did appear to incorporate at least 3 of the 4 stimuli. The cotton puff produced a dream of her sister playing with a cuddly toy lion; the airpuff a dream of a family outing in a boat on a lake, with the wind blowing in her face; and the water a dream that she was with her siblings spraying a fire near her house with a firehose (the emeryboard was associated with a dream of playing at the town park). In none of these cases did stimulus application disrupt REM-sleep patterns by producing wakefulness; in all cases stimulus application was terminated several seconds before the subject was awakened. These three dreams give clear evidence that Subject 5 could report ongoing sleep mentation on laboratory awakenings. Her reports on REM-sleep stimulus-incorporation trials were, moreover, comparable to those she gave on her first two experimental nights and representative of those collected from most subjects in her age group. These

considerations do not resolve the problem of potential confabulation by young subjects, but do add some confidence to

the interpretation that the reports collected in the present study are *dream* reports.

STUDY TWO: DREAMS OF THE MALE ADOLESCENT

This second study, as suggested above, was of interest not only in determining the generalizability of results of dream studies previously conducted with pre-adolescents^{8, 10} but also as an attempt to confirm that a positive association of dream vividness and affect with personality pathology holds during childhood as well as during the young-adult years.

Foulkes and Rechtschaffen¹¹ found (with their results reported here in terms of a subsequent factor analysis of their rating data by Hauri et al.¹⁷) that pathological scales of the MMPI tended to correlate positively with Vivid Fantasy (i.e., word counts, imaginativeness, distortion) of dream content, inconsistently with the degree of Active Control exercised over such content, positively with dream Unpleasantness and Physical Aggression, and negatively with the amount of Verbal Aggression and Heterosexuality in dream content. It was of particular interest in the present study, then, to observe whether a group of adolescents selected for demonstrated pathology would differ from controls in a manner consistent with these earlier correlational data.

SUBJECTS

All boys aged 13 to 15 then resident in an institution for emotionally disturbed adolescents were recruited for service in the study ($n=7$). The boys were from working-class backgrounds with histories of parental abandonment or neglect. A control group of boys in

the same age bracket ($n=7$) was obtained from the community. Two boys of working-class background were approached by an experimenter and asked to serve in the study themselves and to help recruit their friends. This process of recruitment produced a control sample of working-class origin and one within which, as was also true for the institutional boys, all subjects were well acquainted with one another. Each subject was paid for his service in the experiment. Boys in the institutional group ranged in age from 13-6 to 15-9 while those in the control group ranged from 13-11 to 15-7.

METHOD

Each boy reported to the laboratory at an hour approximating his normal bedtime. Subjects were run in pairs, with all pairs but one homogeneous for institutionalization-noninstitutionalization. Each subject served two non-consecutive nights in the laboratory.

Shortly after the subject's arrival at the laboratory, an experimenter affixed electrodes for EEG and EOG recording to his face and scalp. Continuous recordings (a monopolar EOG from the outer canthus of the right eye, one from the outer canthus of the left eye, a monopolar parietal EEG, and a bipolar parietal-occipital EEG) were taken throughout the night on an Offner Type-R Dynograph. Subjects slept in darkened rooms connected to the control room by intercom units.

Awakenings to retrieve dream content

were scheduled 10 min. following the onset of REMs during the first four REM periods of that duration occurring on each laboratory night. All awakenings were made over the intercom system by the same experimenter and were tape-recorded for later transcription. When the subject indicated that he recalled a dream, he was encouraged to give a spontaneous report and was then asked to identify characters and settings and any feelings that he might have had. On occasions when the subject did not immediately recall a dream he was asked to think "for a moment or so to see if anything comes back to you"; if it did not, he was then allowed to return to sleep.

Test Administration. Following the conclusion of his laboratory service, each subject was administered the WISC (omitting Comprehension and Coding subtests) and the California Psychological Inventory (CPI). TABLE 2 summarizes the median scores of each subgroup for WISC and CPI variables and evaluates differences for statistical significance. In this and all subsequent intergroup comparisons, the statistical test employed is the Wilcoxon Rank-Sum Test.²⁰

The institutionalized boys were predictably inferior to the controls on the verbal scales of the WISC, but equalled the controls on the performance scales. Full-scale IQs ranged from 91-136 in

Table 2
TEST SCORES OF INSTITUTIONALIZED AND NONINSTITUTIONALIZED SUBJECTS

	Institutionalized Median (n=7)	Noninstitutionalized Median (n=7)	t-tail significance
Age	14-6	15-0	—
WISC			
Verbal IQ	104	119	.03
Perf. IQ	114	114	—
Full-Scale IQ	110	116	.08
CPI			
Dominance (Do)	23	21	—
Status (Cs)	14	13	—
Sociability (Sy)	20	20	—
Social Presence (Sp)	30	33	—
Self-Acceptance (Sa)	20	18	—
Well-Being (Wb)	22	28	.06
Responsibility (Re)	21	26	.06
Socialization (So)	27	32	—
Self-Control (Sc)	17	16	—
Tolerance (To)	12	11	—
Good Impression (Gi)	9	12	—
Communality (Cm)	20	26	.07
Achievement via Conformity (Ac)	15	20	.08
Achievement via Independence (Ai)	13	13	—
Intellectual Efficiency (Ie)	28	31	—
Psychological-Mindedness (Py)	8	8	—
Flexibility (Fx)	10	11	—
Femininity (Fe)	14	15	—

the institutional group and from 106–130 in the controls. Control CPI medians fell below average standard scores for 16 of 18 scales, but the same is true of high school norms for the CPI for the same 16 scales.¹³ The patterning of their median scale scores was almost identical to that of the high school norms. Institutional subjects showed a median profile usually similar to, but with generally slightly lower elevations than, the controls. The scales that differentiated controls from institutionals indicated greater freedom from psychological distress (Well-Being) and greater conformity and conventionality (Responsibility, Communality, Achievement via Conformity) among the controls. The two groups did not differ significantly in Psychological-Mindedness or other more cognitive dimensions (Self-Acceptance, Self-Control, Tolerance, Flexibility, Intellectual Efficiency).

Analysis of Dreams. The typescript of each REM report was pasted on a file card. The file cards contained no identification of subject or institutional status and were randomly assigned code numbers. These coded cards were then rated independently by two judges, one of whom had been present while the reports had been collected some six months earlier. The other was naive, except for judgments of Verbal Aggression. Ratings were then performed along the following dimensions (Pearson product-moment reliabilities are reported parenthetically): Imagination (.78); Relation to Everyday Experience (.75); Verbal Aggression (.92); Physical Aggression (.91); Heterosexuality (.75); Unpleasantness (.78); Active Control (.80). The first two rating scales, along with substantive Word Counts performed by the naive rater, defined Hauri

et al.'s¹⁷ Vivid Fantasy factor. Two-rater averages were employed in all subsequent analyses of the rating variables.

Two judges, one naive as before, performed content analyses of all dream reports in the areas of characters, settings, and plots. The form of the analyses was identical to that employed previously for 6- to 12-year-old males.¹⁰ Although plot categories deriving from the 6- to 12-year-old sample were not always fully appropriate for adolescents, they were retained to facilitate comparison across age groupings. The two analysts discussed, dream-by-dream, whatever differences emerged from their independent analyses and agreed upon one final judgment for each dream.

RESULTS

Sleep Patterns. Male adolescent sleep latencies to the initial REM period were between previously recorded values for 10- to 12-year-old boys and those for young adults: institutional mean latency was 128.4 min., while control mean latency was 132.0 min. The difference between the two groups was not significant. A familiar finding in sleep research has been the retardation of sleep latency to REM sleep, and consequently a reduction of the percentage of sleep spent in REM sleep, on a subject's first night in the laboratory.^{1, 25} It has been suggested that this effect is mediated by initial anxiety induced by the laboratory. Our control group showed a First Night Effect (a Night 1 mean latency of 152.1 min. and a Night 2 mean latency of 111.9 min., $T=3$, $p=.05$). Recently, however, it has been reported that clinical patients may not show a significant First Night Effect.^{14, 30} Neither did our group of disturbed adolescents (a Night 1 mean latency of 135.6 min. vs. a Night

2 mean latency of 121.3 min.). For subjects with past histories involving submission to professionals for tests and diagnoses of various kinds, the environment of the sleep laboratory is much less novel and extraordinary than it is for the normal control subject. It was evident from their waking laboratory behavior that the institutionals in our study were considerably more at ease there than were the controls, and on both Night 1 and Night 2 they fell asleep more quickly after lights-out. To the extent that institutionalized and non-institutionalized subjects do perceive and react to the sleep experiment in different ways, this poses an additional interpretive difficulty in assessing the heretofore rather inconclusive data on laboratory sleep patterns as direct symptoms or causes of functional mental disturbance.¹⁶

Recall. Some substantive recall was obtained on 39 of 55 awakenings of institutionals (70.9%) and on 39 of 52 awakenings of controls (75.0%). This difference was not significant.

Word Count and Ratings. All predictions were verified as to direction. Institutional dreams were longer (means of 104.1 vs. 83.3 words), and rated more imaginative (mean ratings of 3.37 vs. 2.63, $p=.09$, 1-tail) and less related to everyday experience (2.71 vs. 3.17) than control dreams. They were also more unpleasant (4.22 vs. 3.60, $p=.05$, 1-tail) than control dreams. Control dreams contained more verbal aggression (.55 vs. .22) and heterosexual content (1.23 vs. 1.06) than institutional dreams, but less physical aggression (.95 vs. 1.44) than institutional dreams. Mean activity ratings, for which no prediction had been made, were identical in the two groups (3.49).

Content Analysis. TABLE 3 presents partial results of the content analysis. Data on 6- to 12-year-old boys and young-adult males are taken from a prior study.¹⁰ It is clear from TABLE 3 that institutionals are like young adults in one respect: both groups, living away from parents and siblings, dream of them very seldom. The adolescent controls dream less of family characters than do the 6- to 12-year-olds, but more than do the young adults. Most strikingly, both adolescent groups show a preponderance of unfriendly social interaction dreams, something true of 6- to 8-year-old boys, but reversed during later preadolescence when the ratio was 2.7: 1, friendly to unfriendly. For male adolescent controls, the comparable ratio was 1:1.6 and, for the male institutional, it was 1:12. While the controls increased in work-study plots as compared to the 6- to 12-year-olds, the institutionals increased in the category of diffusely organized travel or movement dreams (riding "around" in a car, etc.).

Amount of Deprivation and Dream Variables. The institutionals were not homogeneous for parental deprivation, nor, presumably, for associated psychological disturbance. To the extent that institutionals had experienced moderately satisfactory relationships with one or both parents, there would be some overlap with the controls. Before any data were collected in the study, the authors asked the social worker from the institution at which the disturbed boys were resident to rank them on the amount and quality of their parental and other social-cultural deprivation. She did this, and, in addition, gave categorical judgments as to the severity of deprivation, placing her judgments in a sealed

Table 3
CONTENT ANALYSIS OF MALE DREAMS AT DIFFERENT AGE-LEVELS

NO. OF DREAMS	Young Adults	13-15 Year Olds		6-12 Year Olds
	72	Institutional 39	Control 39	179
CHARACTERS				
Dreamer himself	84.7%	82.1%	82.1%	83.2%
Family				
Mother	1.4	2.6	7.7	20.1
Father	4.2	2.6	7.7	17.9
Male sibs	0.0	2.6	12.8	24.0
Female sibs	1.4	2.6	10.3	12.8
Any of above	4.2	5.1	23.1	36.9
Age-mates				
Male	13.9	46.2	38.5	29.1
Female	18.1	7.7	15.4	7.3
Adults				
Male	19.5	10.3	10.3	8.4
Female	13.9	12.8	2.6	5.0
Strangers				
Age-mate M	13.9	5.1	10.3	15.1
Age-mate F	19.5	0.0	5.1	10.1
Adult M	27.8	28.2	12.8	29.6
Adult F	25.0	7.7	5.1	17.9
SETTINGS				
Auto	13.9	10.3	2.6	5.0
Familiar buildings				
Residence	12.5	15.4	17.9	15.6
School	6.9	5.1	10.3	.6
Out-of-doors	20.8	41.0	25.6	55.8
Indefinite	16.7	12.8	10.3	5.6
PLOTS				
Recreational	8.3	17.9	20.5	20.7
Work and study	9.7	2.6	17.9	2.2
Social: friendly	43.1	2.6	12.8	20.7
Social: hostile	5.6	30.8	20.5	14.0
Bodily need	2.8	5.1	2.6	6.1
Achievement	13.9	7.7	10.3	17.3
Travel/movement	9.7	25.6	10.3	13.9
Other	6.9	7.7	5.1	5.0

envelope that was not opened until all preceding data analyses were complete. It was then discovered that she had judged three of the boys "severely deprived," two "moderately deprived," and two "mildly deprived."

Comparisons were then made of the dreams of the five boys judged more than slightly deprived with the dreams of

the controls. In spite of further shrinkage of sample size, it was found that institutional/control differences observed above were accentuated for each variable except Verbal Aggression when the two "mildly deprived" boys were excluded from the analysis. The five most deprived boys differed significantly from controls (1-tail tests) in having more imagina-

tive dreams ($\bar{X}=3.60$, $p=.015$), dreams less related to everyday experience ($\bar{X}=2.43$, $p=.03$), more unpleasant dreams ($\bar{X}=4.42$, $p=.015$), and dreams containing more physical aggression ($\bar{X}=1.62$, $p=.09$). The two "mildly deprived" boys had, within the institutional subgroup, the two lowest rankings for Imagination and the two highest rankings for Relation to Everyday Experience. When allowances are made for the fact of some overlap between less deprived institutionals and their controls, the previously noted group differences in dream content are more readily demonstrated and more reliable statistically.

Correlational Analysis. Another approach to the problem of within-group inhomogeneity and consequent overlap between the two subgroups was the correlation (Pearson r) of all 14 subjects' CPI (and WISC) scores with their mean dream word counts and ratings. CPI scores, particularly those for Wb, provide an alternative definition of waking adjustment that might be sensitive to boys in one subgroup showing waking behavior more similar to that of boys in the other subgroup than to that of boys in their own.

The two rating dimensions for Vivid Fantasy (Imagination, Relation to Everyday Experience) were highly intercorrelated ($-.92$). Wb correlated $-.50$ with the former and $.51$ with the latter (both $p=.05$, 1-tail). Overall, 16 of 18 CPI scales correlated negatively with dream Imagination and 15 of 18 positively with dream Relation to Everyday Experience. Additional correlations with the realism scale indicated the most realistic dreams were reported by boys high in social dominance (Do, $.50$, $p=.05$,

1-tail) and intellectual flexibility (Fx, $.45$, ns) and efficiency (Ie, $.40$, ns). All these results are consistent with the pathology-dream vividness hypothesis.

Dream Unpleasantness correlated $-.48$ ($p=.05$, 1-tail) with Wb. Fourteen of this rating dimensions' 18 correlations with the CPI were negative, including Ai ($-.52$, $p=.05$, 1-tail). An interesting exception to this pattern was a significant *positive* association with Fe ($.54$, $p=.05$, 2-tail). Subjects with feminine interest patterns not only had more unpleasant dreams, they also had dreams with more physical aggression ($.43$, ns). Unpleasantness ratings were highly intercorrelated with those of Physical Aggression ($.76$). Other CPI correlates of the latter were To ($-.52$, $p=.05$, 1-tail) and, as predicted, Wb ($-.59$, $p=.025$, 1-tail).

Verbal Aggression dream ratings did not correlate significantly with any test scores. They did correlate negatively, however, with subjects' ages ($-.51$, $p=.10$, 2-tail). Physical Aggression ($.23$, ns) and especially Heterosexuality ($.64$, $p=.02$, 2-tail), on the other hand, increased with age. These results can be interpreted as a lessening of preadolescent intellectualizations of impulses as adolescence is more fully experienced.

Finally, Dominance correlated $.68$ ($p=.01$, 2-tail) with the active character of the subject's role in his dreams. Apparently there is, regardless of clinical status, a direct carryover of the kind of role a person plays in wakefulness to that he plays in his own dreams. This is still further evidence of the continuity, rather than complementarity, of dreams and wakefulness⁹ and directly contradicts the complementarity hypothesis of Jung¹⁸ that the waking extravert is a sleeping introvert.

GENERAL DISCUSSION

The results of these two studies confirm two hypotheses about childhood dreaming: first, that the dreams of the child are generally realistically related to his waking life, and second, that they become relatively more bizarre and unpleasant for children with some dysfunction in waking personality.

Findings for the preschoolers in Study One are perhaps less secure than those for the adolescents in Study Two. There is the possibility, which our efforts at testing subjects' abilities for accurate dream reporting on stimulus incorporation trials and by means of correlated test data did not entirely rule out, that the preschoolers confabulated. There is also the possibility that these subjects were trying to be accurate dream reporters but lacked vocabularies and concepts with which to communicate the true nature of their dream experiences. It might be held, for instance, that their dreams only seem realistic because there were no ways for the subjects to convey the more bizarre aspects of their nocturnal thoughts. Positive correlations of recall by preschoolers with adequacy of the concept of dream on the Laurendeau-Pinard test and with Descriptive Ability Scores cast some doubt on this interpretation. In addition, we noted that subjects' stereotyped conceptions of dreams before coming to the laboratory, probably based on selective recall of their total dream production, were generally that their dreams were "scary," often involving frightening animal figures. They were able to report relatively unrealistic dreams, then. That such dreams were not reported under the representative sampling conditions in the laboratory may be taken as further evidence against the hypothesis that laboratory dream reports

were realistic because the preschoolers were not able to report unrealistic content. It must still be admitted, however, that both the confabulation and communication-inadequacy hypotheses have greater potential application to the preschoolers than to other, older child subjects.

With this qualification, the authors would suggest that their results suggest a coherent interpretive framework in terms of which the dreams of children and young adolescents might best be viewed: the dream as an ego process. In the absence of disturbances introduced by personality pathology, the child's dream is characterized by generally realistic, life-related content in which impulse and affect are noticeably absent. The dream of the young adolescent is more impulse-laden, but this correlates well with the shifting dynamic interrelation of ego and impulse that accompanies the onset of adolescence. In either case, the dream is more continuous than discontinuous with waking ego functioning.

Under conditions of systematic presentation of external stimuli during sleep there is still further evidence of adaptive ego functioning. As the examples of incorporation cited above indicate, the disturbing stimulus is most often displaced or externalized in the REM-sleep dream. Subject 7's electrode chain was wrapped across his neck, but the caterpillar of which he dreamed, without affect, was crawling on his sister's leg. Freud noted, of course, that the dream does not "reproduce" a disturbing stimulus, but "deals with it" in terms of hallucinatory experience.¹² He uses such cases to highlight the role of wishes in dreaming, but they might better be employed in exemp-

lifying the impressive set of ego operations that can be brought to bear upon the representation of an external stimulus impinging upon the subject.

The modal dream content of the normal child appears to be in the area of play and recreational activities. It is difficult to believe that these dreams were invariably instigated by unconsummated wishes from the dream day, as the id-instinctual view of the dream proposes. Dreams of play appear most simply to represent extensions of the child's waking ego impulses to exploration and manipulation of his environment.²⁸

Robert White questions whether there *needs* to be a disturbing wish to set the child's play in motion. Could it not, rather, be in large measure determined by an ego that has its own autonomous and impulse-independent functions? The present results, and those of our studies of preadolescent dreams, are entirely consistent with White's answers to these questions; what he has to say about the child's play applies equally well to the child's dreams. Both are susceptible to the intrusion of destructive id impulses, but neither is a mere passive sounding board on which such impulses create their own ego-alien dissonances. To the extent that the ego is not overwhelmed by childish emotion and impulse, it places its own constructive stamp upon the nature of both play and dream activity.

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DOMINANT LEADERS AMONG SLUM HOTEL RESIDENTS

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Deteriorated single-room-occupancy hotels collect as tenants the destitute who are unacceptable anywhere else. There live addicts, alcoholics, the crippled, the elderly, and the mentally ill, without families. Rich and intimate group life emerges nevertheless. Dominant leaders of the groups provide a matrix of physical and emotional care. Three such leaders, their characteristics, relationships, and functions are examined.

Slum hotels, better known as single-room-occupancies or SROs in New York City, provide housing for urban rejects: alcoholics, addicts, discharges from mental hospitals and prisons, unskilled rural migrants, the elderly without families, and the chronically ill and disabled. Because of this concentration of social and physical pathology, some SROs become conspicuous in their neighborhoods through frequent police and ambulance calls, night fights, and stoop loitering by deviants.

St. Luke's Hospital Center's Division of Community Psychiatry staff has worked intensively in six such buildings. We have come to be impressed by the intimacy and complexity of the tenants' social life, despite endemic individual

suffering and disorganization. This paper concerns our observations about the people who emerge as dominant leaders in the SRO population. The quality of their relationships to their followers, and the functions they perform to protect and control them and negotiate the outer world for them will be examined. I hope to show that these functions are similar to those performed by mental health workers in bridging the vast gap between the single, poor, and sick person and the services to which he is entitled.

Our data is derived from service projects undertaken by our staff to stimulate use of hospital and mental health resources by the SRO population. The target was the total building, viewed as

a semiclosed system. Each of the six buildings housed between 80 and 120 individuals. A social worker was assigned half-time to each building to develop a recreation-rehabilitation program. Previous reports^{4, 5} distill our findings about the quality of group living in these buildings and describe technical and countertransference problems of the social workers.

SRO's: THE SETTING

By conservative estimates some 30,000 of New York City's marginal adults with serious difficulty in caring for themselves in urban society live in SROs. This is the only shelter available to many of them who are unacceptable as tenants anywhere else. Other large cities create similar housing patterns for their rejects. Most tenants are neither sick or socially disturbed enough to be in hospitals, nursing homes, or prisons, nor well enough to use traditionally rendered services effectively.

A large majority of the tenants in our six projects are 40 years of age and older. The men outnumber the women, sometimes by as much as two-to-one. Sixty percent or more of the tenants are Negroes, often from the rural South; whites and Puerto Ricans in varying proportions constitute the remainder. At least three-quarters of the tenants have a major chronic disease or disability such as tuberculosis, heart disease, diabetes, cirrhosis of the liver, crippling, blindness, malnutrition. Social and psychiatric problems are endemic: prostitution, addiction, alcoholism, retardation, schizophrenia, and inadequate personality. Alcoholics account for well over half the population in some buildings. Sixty to ninety percent of the tenants are welfare recip-

ients and most others are sporadically employed in unskilled jobs. Ties to primary family tend to be absent or tenuous, as are church or other group affiliations.

Most tenants stay within a two-block radius of their buildings, many spending days on end, or even years, without going outside. Some do not know how to use buses and subways and feel incapable of traveling alone in the city. A trip to a clinic therefore may be a major anxiety-provoking event. Tenants are well aware of the strongly negative attitude of the surrounding neighborhood toward their building. They also experience the de-personalizing or hostile responses to them from various community institutions, including some social workers, public health nurses, doctors, and other health personnel who have had no exposure to this deviant population in their training. The tenants' response in turn tends to be one of sullen watchfulness, masking fear and resentment.

Passivity, perpetuated by debilitating disease, malnutrition, and severely limited life-choices, creates a vacuum in which sporadic bursts of acting out, such as fights or alcoholic binges by a few individuals with poor impulse control, are sources of vicarious excitement for others.

The passage of shapeless days is rhythmically marked in two-week cycles when welfare checks arrive. This is a day of heavy drinking for some, a meal for others, and extortion and "rolling" by the petty racketeers. Over the remaining 13 days, tenants eke out about \$20 for food and necessities for one person.

To cope with this abject material poverty, the tenants turn to one another

to share scarce material resources and emotional ties. The lives of all but a few of the tenants are actively intertwined, a finding which sharply contradicts the stereotype of the single, poor individual as reclusive. Groups exist whose members give mutual support to each other's deviant or maladaptive behavior, but who also provide the human association, the sense of some help and belonging, which makes physical survival possible and emotional life meaningful.

Some groups are made up of three or more people who regularly share activities, such as splitting a bottle, playing cards, or visiting in each other's rooms. There is a good deal of brawling and, occasionally, fighting with knives in some of these cliques; none in others. The alcoholics and addicts mutually exclude one another. Of the two groups, the alcoholics have a richer and more stable social life, but the addicts also know one another well and tend to develop pairs or triangles of relationships. The addicts move from one SRO to another more frequently than alcoholics because of surveillance and narcotics raids. Mentally ill and retarded individuals attach themselves to groups of alcoholics as marginal members; a very few remain isolates.

Dominant individuals, around whom group life revolves, vary in personality and leadership style. Some pimps and some pushers are consistently exploitive and sadistic to their followers; others foster extremely primitive regression and dependency. A recurrent pattern is the matriarchal quasi-family in which the dominant woman tends to feed, protect, punish, and set norms for "family" members. They share some meals, and the room of the leader is a hub of

continuous social activity. Many of these women have thinly disguised contempt for the men in their care; they prefer a domineering role which emasculates the men who, in turn, relate to the women passively.

THREE MATRIARCHAL LEADERS

Among these matriarchal leaders of quasi-families there are three who wield unusual personal influence and engage in activities analogous to those of the mental health worker. These three have a large and stable following in their respective buildings, and they function within the power thus bestowed upon them to support, nurture, heal, and sometimes infantilize those in their care, in effect being a "good mother" to a highly dependent group of physically and emotionally ill people. In the microcosm of the SRO, these three leaders have a high level of energy, the capacity to negotiate the world outside, and to remain active and resourceful in the face of poverty in comparison to their followers. The latter, in turn, vastly enhance the power of the leader, not only because of the reality-based protective, feeding, and controlling functions she provides but also by the parental omnipotence with which they endow her.

These leaders try to organize and distribute the sparse material resources available, such as food, cigarettes, clothing, money, wine, and medication (including aspirin, antibiotics, and tranquilizers). They also try to organize an effective mutual aid system, to prevent decompensation or violence where possible, to mediate for their followers for needed services at the hospital, the welfare center, or the police station, and

even to handle medical and psychiatric crises.

All three are Negroes between the ages of 40 and 55 and all were on welfare when we first knew them. They had experienced lifelong family disorganization and poverty. However, they had finished high school, an educational level five grades above the mean of the SRO population. All are chronic alcoholics and have severe medical problems: heart disease, high blood pressure, obesity, cirrhosis of the liver. They have been in jail at some time in their lives for assault, petty larceny, or drug pushing.

A sociometric analysis⁷ of interaction in one of the buildings with 104 tenants shows that the leader was chosen by a total of 40 tenants as a desired partner with whom to share activities, while she chose 7 tenants. Thus more than one-third of the tenants in this building look to her for a fantasied or real relationship. We do not have sociograms for the other two but the strong impression is that a similar situation exists in their respective buildings.

This degree of affection and dependence seems to be stimulated by the leaders' capacity to fulfill to some extent several basic needs: (1) direct oral gratification, (2) control of disruptive behavior, and (3) assurance of group support for the individual. The following are examples of each type of activity on the part of Mrs. Smith, Mrs. Crawford, and Mrs. Johnson.

ORAL GRATIFICATION

Mrs. Smith picks up, and has others pick up, cigarette butts which she keeps in an open jar in her room; anyone out of cigarettes can help himself.

Mrs. Crawford regularly collects large

quantities of staples from welfare surplus foods and keeps cooked dishes warm and ready to feed tenants who have run through their welfare checks on wine or drugs, or who have been rolled. Mrs. Crawford also recognizes the symptoms of D.T.s and keeps wine hidden for such an emergency.

CONTROL OF DISRUPTIVE BEHAVIOR

Mrs. Johnson shames people who fight dangerously or argue abusively by calling the group's attention to their behavior. In extreme cases she will call on a strong ex-boxer to halt the fight. She does not intercede with those in the building whom she does not know well.

Seven alcoholic tenants regularly turn over their welfare checks to Mrs. Crawford, who then doles out a dollar or so a day until the next check. Those using Mrs. Crawford as banker give the following reasons: they are less frequently robbed; they do not drink it all away; and they are not hungry on the last days before check-day.

Mrs. Smith has gathered a miscellaneous supply of psychiatric drugs. She encourages those who have come from state hospitals to stay on their prescribed drug regimen and, on occasion, gives an acutely disturbed tenant some form of tranquilizer.

GROUP SUPPORT

Mrs. Johnson visits many of the bed-ridden tenants in her building, feeding them and nursing them. She takes care of the burial arrangements if, as is usually the case, no family appears. When a senile tenant whom she had looked after for years died, she took up a collection from other tenants to prevent burial in Potter's Field.

Mrs. Smith is aware of the arrival of new tenants and finds ways to help some of them into the social life of the building. By this route, they become grateful to her and subsequently loyal.

Many of these actions echo the parental role in large primary families. The members of Mrs. Crawford's family describe their relationships to each other, as: "We're like a big family." "They are all my brothers and sisters." "All for one and one for all, that's the way we are."

MEDIATORS BETWEEN TENANTS AND THE ENVIRONMENT

The three leaders have in common vivid, expressive, and forceful personalities; they tend to show a wide range of emotion—love, pity, anger, remorse, empathy, and humor—to those in their "family" and to outsiders to whom they have built a close relationship. They establish rapport with outside sources of power whenever possible; personal contact is made with the local policemen, welfare investigators, managers, and other service people on whom the tenants depend. Sometimes a mutual bargaining develops between the leader and these people, a byproduct of which is better service to the tenants. Here are some examples of these skills in action:

All three leaders developed an uneasy alliance with the building managers. The managers recognize the positive value of the leaders as an economic asset: through them property is less damaged, turnover reduced, public disturbances lessened. In emergencies, illness, death, robbery, fire, or psychiatric crises, they often work as a team.

Mrs. Johnson often determines the need for an ambulance, asks the man-

ager to call the hospital for it. Then she rides with the sick tenant and keeps track of him in shifts from hospital to hospital, state hospital, or prison. She pleads with the manager to hold his room for him, safeguards his belongings, arranges for his welfare check to be suspended or continued as appropriate, and welcomes the tenant to the building when he returns.

Mrs. Crawford rehearsed an inarticulate and frightened tenant in requesting a clothing grant from his welfare investigator. She then met the investigator in the hall and carefully explained the tenant's timidity in making the request.

Mrs. Smith was aware of the practice of a hospital admitting clerk who discouraged alcoholics from being admitted for emergency care. She became friendly with the staff and this clerk of the emergency room in the course of accompanying her tenants to the hospital. Gradually they came to recognize her, to respect her judgment about the medical problems of tenants she brought for treatment, and became interested in her building.

LEADERS AND PROJECT WORKERS

The intrusion of the community psychiatry worker into the leader's life and turf was accompanied by some mutual mistrust and competitiveness between them. But gradually a close relationship was established, and each learned from the other.

The worker learned, at times painfully, a style of relating to the tenants which was similar to that of the leaders, who were highly sensitive to emotional dishonesty and mechanical interventions. This style included touching, hugging, physical nearness, mutual sharing of cig-

arettes, the giving and accepting of food, and visible, direct, immediate emotional responsiveness—attention, delight, annoyance, boredom, anxiety, admiration, and affection. The leader understood the worker's initial anxiety and made it possible for her to begin to delineate a helpful role. Here is an example from a worker's records of the opening phase:

It was my first visit to an SRO. I kept mouthing all the comforting phrases which I had heard at the office: "They're just people." "The murders, face slashings, have all been calmed down." I had never seen an addict in my life; would he know what I was thinking? I politely entered the room and extended my hand to everyone who came up to me. One man, large and disfigured, squeezed my hand hard; he would not let go. I guess my face showed a flash of panic and I tried to jerk my hand away. Another tenant (Mrs. Johnson), seeing my need, came over and whispered to me, "You just gently ease your hand away and talk to him." It worked.

What often appeared to be a sexual approach by tenants was bravado, a thinly disguised hunger for closeness and dependency and recognized as such by the leaders and, in time, by the workers.

The leaders also gained greatly from the workers. Early in the project, the leaders' contact with the hospitals or welfare was sporadic, their knowledge of resources limited, and the range of tenants cared for was a matter of personal bias. In a positive identification with the worker, they made more effective and sophisticated referrals. They began to work with new agencies, such as housing bureaus, neighboring tenants' associations, and churches, in efforts to get services and to change the image of the building in the community. As this shift took place, they became busy and important people in the larger community and their own symptomatology decreased.

DISCUSSION

Under the impetus of Federal poverty programs, there has been an increasing interest by the service professions in the problem of indigenous leadership among poor minority groups. This interest has been expressed in two widely different arenas: (1) community organization, where professionals seek out eloquent and active people who, with help, can assume political power in their local communities, and (2) subprofessional training, where indigenous nonprofessionals are used as ancillary personnel in service organizations such as hospitals, social service agencies, and schools. Pioneering efforts in the selection, training, and utilization of such personnel have recently been reported.^{2, 8}

The SRO leaders' usefulness seems to lie neither in the political arena nor in the service organizations. They are frequently too vulnerable and eccentric to tolerate job frustrations, and too debilitated physically for full-time regular employment. Also, there is little incentive for many of them to give up their positions of authority in their buildings to fill low-status positions in a professional world.

The majority of the leaders are valuable precisely because they live and work, albeit haphazardly, with a community of unrecognized patients who, in the usual course of events, would never be seen by a psychiatrist. They perform an invaluable service, for, as far as they are able, they mitigate potential disorganization in response to stress and reduce disturbed behavior and neighborhood blight. They are, in fact, the unpaid and invisible staff of nameless and unendowed half-way houses—the SROs. That such altruism can exist at all un-

der circumstances which often produce greed, that within an intolerable living situation the creation of a quasi-family can occur, is a tribute to the human being's boundless adaptive capacity to find and use others in his struggle for survival.

The mental health professional's task is to seek these gifted leaders out and increase their knowledge, confidence, and skill, without separating them from their group and, in the process, creating conflict for them. Caplan and Grunebaum¹ pose the question as applied to a wider range of informal care-givers:

Individuals in crisis often turn for help, not to professional care-givers, but to people who live or work near them, whom they have learned to know and respect. Such informal care-givers include neighbors, druggists, bartenders, hairdressers, industrial foremen, etc. They are chosen by people as confidants because of special personality gifts—capacity for empathy and understanding, an interest in their fellow men. How can we make contact with them and how can we educate them so that they give wise counsel to those in crisis who seek them out?²

However, I hope it is clear that the work of leaders and workers alike in these buildings is, at best, a bandaid on a massive sore. The ultimate treatment must be directed toward the causes of social disequilibrium which produce abandoned, sick, and frightened people in the city with regularity and in great number. The human suffering and neglect which is encapsulated within these

buildings is so gross as to be incredible, overwhelming, and painful to accept as a social reality in the United States in 1969. The SRO population is very nearly invisible to a large segment of the helping professions. It is a family portrait of our major failures in understanding and skill as helpers, healers, and social engineers. A vivid picture emerges of inadequate medical and psychiatric care and knowledge, antiquated housing regulations, punitive welfare legislation, and depersonalization and rejection by our society of its least adequate members.

But SROs can also be viewed positively, as laboratories where we renew our faith and optimism about the related, loving, and helping qualities inherent in deprived and damaged human beings.

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DELIVERY OF SERVICES

SOCIOPSYCHIATRIC REHABILITATION IN A BLACK URBAN GHETTO

1. Conflicts, Issues, and Directions

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Differences, problems, and conflicts need not be only disruptive. Once recognized, understood, and responded to, they have the potential for becoming growth-enhancing and change-producing. In the course of the development of a multiservice community-based rehabilitation program in Central Harlem, problems and conflicts have arisen which underline issues relevant not only to community mental health but far beyond. The necessity of concentration on the provision of services and on meeting imperative needs has caused full consideration of these issues and their implications to be deferred far too often. This is the frequent fate of new service programs. Yet, for this and for similar programs to be viable and effective, such

consideration must take place. It may well begin with an identification of the issues; it may well end with decisions, strategies, and implementation being planned, productive, and revolutionary rather than unplanned, unproductive, and evolutionary.

BACKGROUND

Harlem Hospital Center is situated in Central Harlem, a slum ghetto neighborhood with a high incidence of unemployment, poverty, substandard housing, narcotics addiction, public assistance, juvenile delinquency, and poor health. The neighborhood ranks among the lowest in per capita income for the city. Admission rates to state mental hospitals are among the highest in the city.

EDITOR'S NOTE: The group of papers published here were developed from a symposium presented by the staff members of the Division of Rehabilitation Services of Harlem Hospital Center at the 1968 annual meeting of the American Orthopsychiatric Association, Chicago, Illinois. They represent a point of view regarding delivery of services to a black community by a group of professional, militant Negroes who have made being black a significant element in their delivery of services.

The people of Central Harlem are black people. They come from north and south, from small town and metropolis. They comprise several social classes, from the relatively comfortable financially, to the growing middle-class, to the large number of working class, to the increasingly large numbers of underclass—those who have never been able to move to the ranks of the regularly employed, even in marginal occupations. They have differences in life experiences, expectations, and styles of living; they move with varying degrees of restriction within the ghetto and in the wider city. They have all experienced the direct or indirect effects of racism, discrimination, and prejudice.

PROGRAMS OF THE HARLEM REHABILITATION CENTER

The Harlem Rehabilitation Center is the community-based facility of the Division of Rehabilitation Services, Department of Psychiatry, Harlem Hospital Center. Through staffing, organization, and programs, the center provides experiences in human renewal for hundreds of Harlem residents—patients, clients, families, staff, and community groups. Its programs employ and train as its primary rehabilitative staff persons from the community who might otherwise be unemployed or underemployed.

Rehabilitative services are organized into three programs using multiple group approaches in a therapeutic community and providing interdisciplinary services. Each program provides:

Social and community services including: (1) The provision of family services in the intensive service programs for an average of three persons per primary patient or client; and (2) Community services: community organization and so-

cial action, generally in cooperation with other community groups; consultation, education and referral; neighborhood service in crisis situations; and collaborative placement in community agencies and industries.

Health services (medical and psychiatric) including: nutritional and health education; the expediting of medical care; crisis intervention; psychopharmacology; and individual and group psychotherapy.

In addition to these services, each program has specialized features:

Psychiatric Rehabilitation Program—a daily intensive service program. Provides sociotherapeutic adjustment activities: socioeducational skills development; group leadership development; resocialization and communal activities; creative and expressive living activities; therapeutic group meetings; and other sociotherapeutic services.

Vocational Rehabilitation Program—a daily intensive service program. Features prevocational evaluation; personal adjustment training; individual and group vocational counseling; therapeutic group meetings; prevocational training; collaborative community work placements; job referral, placement, and followup. Training is provided in clerical skills, cafeteria and food trades services, messenger, maintenance, and custodial services. A hospital industries program is planned. For clients with other aptitudes, advanced training elsewhere is arranged.

Continuing Rehabilitation Program—a limited service program. Serves persons who have participated in or completed one or both of the intensive programs but who can still benefit by participation in other center activities, or who might better be served in an after-care program currently lacking in the

community, or who are in need of re-socialization alone. Provides socialization activities; employed members counseling groups; work-for-pay activities; after care; group medication; and collaborative placement in other community programs.

The largest number of the center's staff are in the categories of paraprofessional Psychiatric Rehabilitation Worker, Educational Skills Worker, and Research Worker. In the *service programs* Psychiatric Rehabilitation Workers are the primary rehabilitative agents, providing, according to their training, sociotherapeutic and socioeducational services, case and community services, health service expediting, and vocational services. In the *training programs* paraprofessional staff serve as peer trainers, trainers of others, and participants in the preparation and presentation of training materials, reports, and publications that disseminate information, educate others, and comprise part of in-service staff development. In the *research programs* paraprofessional Research Workers serve as research interviewers, data collectors, and analysts.

Members of the interdisciplinary professional staff provide indirect patient service as program planners and developers, coordinators of programs and services, consultants, administrators, supervisors, and trainers. As members of the rehabilitative team, they also provide the direct services that require professional knowledge and skill.

In the course of developing its programs, the center has experienced progress and problems, good fortune and mishaps. An attempt to discuss any of these developments or their significance as if each were unilaterally determined would be simplistic and unsuccessful.

Nevertheless, three general categories can be specified for consideration of their implications: first, the relationship between philosophical orientation, goals, and practice; second, the nature of the rehabilitative process; and third, transactions between the wider society and institutions in the urban slum ghetto.

PHILOSOPHICAL ORIENTATION, GOALS, AND PRACTICE

Philosophical assumptions, personal or professional, implicit or explicit, overt or latent, are of a high degree of significance. They define the operational context in which actions are considered, assign values and priorities, determine designation of goals and choice of models, prescribe the steps to reach the goals, and weigh the power of the roles the actors assume.

Late in 1966 the Division of Rehabilitation Services conducted a survey of 35 human service agencies in low-income neighborhoods in New York City whose findings are relevant to this discussion.⁴ Staffs of these agencies were questioned regarding agency philosophy and goals, group mental health services, and issues of concern.

The largest number of agencies (11) were classified as holding a clinical-psychiatric orientation with implicit goals related to a decrease in psychopathology through psychotherapy and a focus on psychiatric diagnosis and status. In these agencies covert philosophy, structure, and leadership imposed the nature of practice. A hospital-sponsored and -based program or a training institution or a mental hygiene clinic tended to follow clinical psychiatric practices because this was "what they were supposed to do" or "this is all they ever did."

On the other hand, there were two classes of institutions with both clearly expressed philosophy and planned efforts to translate philosophy into practice. One class consisted of agencies with a sociopsychiatric orientation. Their expressed goals related to improved psychosocial functioning through the use of social, psychiatric, environmental, and educational approaches, generally in combination. They focused on intrapsychic, interpersonal, and social factors and their interrelationships. They tended to be the deviant or avant garde institutions, professionally sponsored, frequently community-based. The other class with clearly defined philosophies were the agencies with a socioeconomic orientation.

Certain of the assumptions underlying the activities of the Harlem Rehabilitation Center seem, at this point in time and place, to have been most highly valued in its development. This is not to say that the center has been able to make an effective translation of philosophy into program. Rather, it is to make an affirmation of philosophical orientation, dealt with elsewhere at greater length.² Those important assumptions are:

1. The assumption of a personal humanistic philosophy.
2. The acceptance of the developmental view of man.
3. The assumption of the transactional nature of man and society.
4. The value of the concept of imposed social position.
5. The usefulness of the social systems approach.
6. Emphasis on the necessity for mobilizing potential for change and growth.
7. The belief that services exist as

a means to individual and group change.

8. The belief in the necessity of altering and broadening the realm, goals, and methods of mental health concern.

From these eight philosophical assumptions there emerge goals, means, and elements essential to programs of rehabilitation for persons handicapped or disabled by mental disease, social disadvantage, and/or social disorder.

Rehabilitation is defined as the process whereby individuals are restored to socially and interpersonally productive roles, within the limit of their potentialities, with recognition of their disabilities.

Sociopsychiatric rehabilitation is that form of rehabilitation characterized by the use of multiple, comprehensive, coordinated interdisciplinary interventions directed toward aiding individuals to achieve optimal social, psychiatric, educational, and vocational roles within their capacities and potentialities. The range of these interventions includes, but is not limited to, therapies, activities, services, assistance, education, training, self-development, self-help, advocacy, and individual and group social action.

The referents of sociopsychiatric rehabilitation are intrapsychic, interpersonal, and social (in the broad connotations of education, work, leisure, and the relationships between individuals, groups, and other social institutions).

The goals³ of the Harlem Rehabilitation Center therefore are:

Service

1. To develop and utilize sociopsychiatric group rehabilitation approaches to provide social, psychiatric, educational, vocational, and community ser-

vices to persons discharged from psychiatric hospitals and/or with severe chronic mental illness.

2. To provide related rehabilitation services and assistance to family and community individuals and groups in order to assist, directly or indirectly, in the rehabilitative process.

3. To serve as a force for individual, group, and social change through the operation of preventive, habilitative, and rehabilitative systems and their transactions with other social systems, directed toward altering psychological and/or social disorder.

4. To develop and implement relevant and effective systems of human service, participating in this development with other members of the professional, paraprofessional, and lay communities, including recipients of service.

Training

1. To identify and define professional and paraprofessional roles in sociopsychiatric rehabilitation and in other human services.

2. To develop, train, and educate professional and paraprofessional personnel.

3. To develop new staffing patterns and training procedures applicable to rehabilitation, mental health, and other human services.

4. To develop and make legitimate new careers in the human service fields, particularly in mental health.

Research

1. To study the course of recovery from severe chronic mental illness.

2. To describe, assess, and evaluate the course of sociopsychiatric rehabilitation and of other mental health services.

3. To determine the optimal pattern

of professional and paraprofessional staff to provide sociopsychiatric rehabilitation services and to appraise the functioning of such staff.

4. To study the relationship between socioeconomic and other environmental factors and personality development, mental health, and mental illness.

5. To evaluate the impact of such services on community health, mental health, and social welfare.

6. To apply knowledge acquired to the development of human service programs.

7. To develop preventive interventions to reduce the incidence of mental illness and of disabilities from mental illness.

The *vehicle* to accomplish these goals is the Harlem Rehabilitation Center, a community-based multiservice interdisciplinary rehabilitation center.

The *means* to reach the goals are programs of service, research, and training, integrally and transactionally related to hospital, local, and wider community activities.

The *model* chosen is the social systems model. A social system is defined as a complex of social elements or components directly or indirectly related in a causal network, such that each component is related to at least some others in a more or less stable way within any period of time.¹ This construct is considered useful in the development of programs of change intervention and in viewing a number of change processes in subsystems under consideration. These processes include controlled interventions, a variety of therapeutic techniques, and other natural alterations in various social systems—the dyadic relationship, the small core group, and larger, more peripheral groups.

The elements deemed essential to sociopsychiatric rehabilitation programs are social, therapeutic, educational, and environmental.

Each is *social* in that human relationships and the social context are essential to its implementation. Within the framework of staff, patients, and clients acting as change agents in various social systems, group forces—goals, sanctions, leadership, norms, identification, and support—are used to mobilize the change potential in each individual and group. Planned activities and personal contacts are directed toward socialization, resocialization, and the development of meaningful interpersonal relationships.

In the *therapeutic* features, therapeutic relationships and activities, pharmacologic therapies, crisis interventions, and health services are directed toward psychosocial adaptation, social learning, and physical health.

The *educational* emphasis focuses also on social learning as well as on skills development (avocational, prevocational, and vocational) and the acquisition of knowledge.

Finally, the *environmental* features relate to control over the decisions affecting one's life and control of the environment, as well as the development of potential for constructive action in the social environment.

For rehabilitation, a sociopsychiatric orientation which takes into account the psychological, social, and behavioral referents seem appropriate. Here goals reach beyond those of restoring a previous state of equilibrium, of handling symptomatology, or of dealing solely with reality problems. They encompass also helping an individual to achieve his own potential, to improve his social

functioning, and to relate more effectively with his familial and social environment. Practices following such an orientation use the rehabilitative process to increase personality integration, social skills, and ability to cope with the world around one. This approach seeks further to develop innovative measures that not only identify and work toward strengthening positive intrapsychic and interpersonal forces but also identify and assist in the circumvention and alteration of negative external forces which impinge upon the lives of individuals and groups.⁵

The dynamic developmental view of the nature of man is integrally linked with the primacy of emphasis on change. It takes into account man's past and present experiences; his view of his many selves—public, private, idealized image, the good me, the bad me, the self as seen by significant others; his intrapsychic world, his real world, his fantasy world; his hopes and aspirations; his relationships with others and with his environment; his conflicts, fears, defenses, and adaptive mechanisms; his need for autonomy; his dependence on meaningful relationships. They are seen not as fixed and unalterable but, for each individual, subject to varying degrees of modification through the vicissitudes of life experiences and through planned change experiences, either of which may be therapeutic and growth-enhancing or antitherapeutic and growth-reducing. Rehabilitation services which accept this view of man seek to utilize and develop numerous positive change experiences and to utilize environmental stress to aid individuals in their ability to cope successfully.

The broadened view of the realm of human services, particularly of mental

health services, leads programmatically to consideration of a number of areas not traditionally considered relevant to psychiatry and psychology. From this viewpoint the causal, historical context and the immediate political, social, and economic structure that perpetuates damaging personal conditions today are considered relevant influences on personality and on functioning. Thus, attention is paid to the ways in which personality development is altered by the fact that a person is judged to be expendable from the moment of his birth simply because he is black or, contrariwise, valued more highly because he is white. Such issues as the decentralization of mental health services, community control of health services, new careers and roles in human services, methods of intergroup communication, the development of new models incorporating both the social and medical systems become ripe for such interdisciplinary attention, as do the transactional relationships between a dominant society and the many subsystems in it (handicapped people, unemployed people, mentally retarded, mentally ill, or socially disadvantaged groups).

This view recognizes the limitations of the mental health field to deal with these issues alone even as it acknowledges their relevance to the field. Thus it acknowledges the programmatic necessity of interdisciplinary efforts and of collaboration with other behavioral sciences, with education, and with the recipients and consumers of services.

THE NATURE OF THE REHABILITATIVE PROCESS

Some of the significant issues emerging in the Harlem Rehabilitation Center are related to the changes undergone by

staff as a direct outcome of participating in new roles in the rehabilitative process. Others are an indirect result of the problems inherent in any new program—innovative, lacking in precedent, and beset by underbudgeting, lack of supporting staff, and the pangs of growth and development.

For most new programs such struggles and "growing pains" are almost inevitable. Energy is expended in moving from role diffusion to role definition, in helping supervisory staff couple their rightful demands for responsibility and authority with their own follow-through and accountability, with accepting the fact that what seems ideal in the proposal may prove unworkable in the program. Modifications need to be thought out, yet often turn out to be hurried; they need to be planned, but frequently must be expedient. Hopefully, learning takes place so that past mistakes are not repeated too often. This requires not only the identification of the error; people are usually quite willing to do that. It requires an equal willingness to find solutions and participate to make them workable.

The increasing gap that separates the planners of programs from those actually providing service places the program planners and administrators either in the position of being incarnate benevolence (the providers of all good things) or incarnate evil (thwarters of all constructive plans). Frequently these views are held by the same people at the same time, including the planners and administrators themselves. Such views influence and alter the relationships between the line personnel and supervisory personnel who become middlemen. This resultant tension may carry over to mem-

ber or staff groups who may view supervisory staff as parental figures fighting for control, as irrational authority, or as proof that "you can't beat the system." Sensitivity training sessions, self-perusal, and a continuing willingness to listen may be difficult, but have a definite contribution to make in keeping these conflicting views and the resultant behaviors from being defeating. Indeed these effects can result in opening up channels of communication, in restructuring roles and limits along more constructive lines, and in enriching participation through improved morale.

Since the errors made at a top level are more likely to be programmatic and policy-related, they may be easier to admit. They seem more abstract, less related to the day-to-day operational errors that can be more readily identified and pointed out by members as well as by staff. For the clinician in such a setting, particularly the psychiatrist, open discussion and questioning by other staff is novel, even after he admits his errors; the medical model has made his position invulnerable, his authority unquestioned. Yet for programs such as this, multidisciplinary in respect as well as in structure, with an attempt to use the therapeutic milieu for patient good, such openness is absolutely required for effective action.

Thus the patients, clients, and staff in new programs which are also developing new approaches in new fields in a rapidly changing society must inevitably experience change. Hopefully this can be a change toward growth. They must, almost as inevitably, experience confusion, but hopefully order will emerge from chaos. They must experience the newness of difference—different people, different demands, different roles, different disciplines; but planfully difference will be

equated not with danger but with cooperative, functional respect.⁶

When some of the decisions over which staff have labored long and laboriously and arrived at through reasoned consideration are outwardly the same as those which had seemed wisest to them intuitively six months earlier, it is easy to hope that the process will be shortened the next time. But the next time is *never* this time, and to assume that it would be so would be to deny the transactional nature of human behavior—in relation to process, time, person, setting, and their effects upon each other. Each point in time presents its own challenges, its own demands.

One of the goals of new programs such as this is increasing the coping and learning skills of patients, clients, and staff so that there is available to them a wider range of choices from which they can wisely select. Characteristically, staff leadership, perhaps through the wisdom of years that leads to uncertainty, may see many alternatives, whereas supporting and supervisory staff, younger and more certain, may see in any given situation fewer alternatives. Each may in time modify, one in the direction of narrowing the range of choices, the other in decreasing the rigidity with which the choice is made. The variety of working relationships required and the need to understand and relate to many kinds of personalities are used experientially to educate staff to relate therapeutically to many kinds of members and families, as well as to develop their own skills in combining flexibility with decisiveness. Thus behavior is not bound to be impulsive, restricted, and self-defeating.

Change in behavior is most striking in the paraprofessional staff, in their increasing ability to perform effectively in

work. Change comes most slowly in non-clinical professionals unaccustomed to self-exploration, but it *does* come. It is seen in the gradual ability of persons from various professions—vocational rehabilitation counselors, nurses, psychiatrists, psychologists, social workers, and clerical staff—to learn to perform in a multidisciplinary, multiservice center.

Within the whole field of rehabilitation, not only in poor communities, there may be a need for a new occupation—that of the trained Psychiatric Rehabilitation Worker, closely linked to the world into which the patient or client is to become rehabilitated and capable of assisting the patient in learning skills to cope with that world. This occupation may have validity beyond the use of such staff to bridge the gaps in communication, to make up for manpower deficits, or to aid the professionals. As such, it will have to be afforded legitimacy and recognition as a new career, with options to move into related fields, to move to higher levels in the new field of socio-psychiatric rehabilitation, or to enter traditional professions, all with due respect and financial compensation. If there is such a role, it is important to learn its characteristics and its effect upon the course of rehabilitation.

An attempt to begin to describe the rules of paraprofessional rehabilitation workers in the Harlem Rehabilitation Center would reveal a wide variety of activities from the point of view of the individual, the group, the therapeutic task, and the worker and his colleagues. The Psychiatric Rehabilitation Workers are the center's primary rehabilitative agents. They use themselves in therapeutic relationship roles, in crisis intervention, and in ongoing therapeutic interventions; as leaders of rehabilitative ac-

tivities, groups, and meetings; as teachers, counselors, trainers, expeditors, and providers of assistance; as role models and catalysts for the development of leadership potential in members and clients; and in numerous other change-agent roles required in the rehabilitative process.

There may or may not be indicators in these programs of elements of services of special effectiveness with poor people and with people who live in ghettos. If so, there is a need for them to be identified and for those features to be designated which are common to other social institutions within the particular community, as well as those specific to the process of rehabilitation wherever it may take place.

Observations of tasks and descriptions of programs, including these, have been until now largely impressionistic, as so often occurs with treatment programs. Specification of the process of rehabilitation, definition of the relationship between particular activities and outcomes, and the weighing of certain variables as opposed to others may provide information about those processes which facilitate change. Until such studies have been done, programs will continue to be planned, but such factors as the change that occurs as a function of time and the sources of rehabilitation that occur outside of formal programs will be largely unexplored.

SOCIAL FORCES AND REHABILITATION IN THE URBAN SLUM GHETTO

But what of life beyond the center? Life is not organized; life is not within one's ability to plan, control, and execute according to one's needs, even when those needs are consistent with the com-

mon good. Is there anything that can emerge from settings which use struggles toward growth to modify behavior constructively that can be applied in a wider context? Can observations, for example, on the transactions that take place between the center and the informal groups, organizations, and people of the neighborhood contribute to knowledge of group process, of attitude change, and of their relationship to behavioral change?

There is an easy path of transposing what goes on within small groups to larger social institutions, to extrapolating from individual psychology to sociological phenomena. This is a dangerous path to take. On the other hand it should be pointed out that many of the issues with which staff and members in the center are grappling are similar to issues confronting local community groups and larger social groups. There come to mind such areas as leadership and authority; as control of the decision-making process; as power and powerlessness; as distinctions between those who set, who disobey, who conform to the rules; as the difference between the titular seat of power and the true power; as man's efforts to cope with increasing dehumanization, anomie, and brutality.

The knowledge to be gained from observing and analyzing the process of change within such settings can, with knowledge generated by the joint efforts of psychiatry and other behavioral sciences, contribute to the development of models effective in dealing with crucial situations demanding social and institutional change. Certainly the need is critical for mental health to widen its horizons, to learn and contribute to the demands faced by the nation today in the racial crisis, mounting poverty, the

high priority of the escalation of a senseless war of destruction.

The decision to choose between concentration on services or social change does not come easily. The service model may evolve into the social change model or a planned blending of the two may occur. Yet the question of emphasis—on service or social change—remains. The deficits, discrimination, and deprivation that a white racist society has imposed upon black America are far too striking, too devastating, too incendiary to be put aside until democracy has been achieved on the political and economic scene. Yet services have been used to accommodate to the status quo, to pacify with tokenism, to conciliate with false change, while the underlying causal or complicating conditions are neither recognized nor altered.

Human service institutions in the black community have the responsibility to contribute to the possibility that there can be an alternative to the waste of human resources, both through pacification with services and through disregard of underlying causation. This means assuming an active relevance to this day. This involves being not only *in* the black community but *of* the black community. Just as the sociopsychiatric approach in rehabilitation does not deal solely with suppression of symptoms but works toward a basic change in the individual in the direction of his ability to act in social health, so the goals for the social environment toward which the black institution in a changing society must work—particularly the black rehabilitation institution—are to support those forces, groups, and actions that alter constructively toward the development of individual and group potential.

In the course of such efforts, other

fields of human behavior beyond those in rehabilitation may become enriched. For there will be questions asked, and hopefully, answers found. What are the special areas where professional mental health skills are most applicable? What are the roles of the black social institution and of the racially integrated institution? What are the methods whereby the local community—in its broadest sense—can assume control over the specification, allocation, and delivery of human services? What means are there to make short-term progress without destruction of life and property? What means can be effective in changing the behaviors if not the beliefs of white America, whose violence and racism have brought the nation to the point of crisis? What are the strategies effective in changing national priorities from the military and destructive to those which could fulfill human needs?

Perhaps group conflict can be resolved. Perhaps the strengths of the ghetto can be multiplied. Perhaps the man, woman, or child of the slum can lead a less deprived life. The effort must be made, not for the slum dweller alone but for the existence of this nation. There is knowledge which can contribute to solutions for individual and common good available to those who live and work in deprived communities and to those in

positions of power in the wider community. There must be the awareness to sense the crisis, the wisdom to ask the right questions, and the openness to understand the answers. But, most of all, there must be the commitment to turn knowledge into action for the good of man.

In asking these questions and in providing these services, it becomes strikingly evident: the provision of services is not an end in itself. Instead it is a means to change, to the change that is growth for an individual and for groups of individuals. Equally as important, it is a means to social change.

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2. Innovative Treatment Roles and Approaches

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"Mental health is freedom", states Matthew Dumont.⁹ "It is the widest conceivable range of choice in the face of internal and external constraints. . . . The freedom of the psychotic is limited by his inability to distinguish between stimuli from within and those from without. In the same way, the freedom of the slum dweller is limited by poverty, unemployment and segregation. In all cases, the final common path is a restriction of opportunity and narrowness of choice. The purpose of psychotherapy and social change are to widen the range of possibilities, to increase the options of human behavior. In short to enhance freedom."

If mental health services are to have significant impact upon social institutions as well as individuals, those who plan and direct programs must look beyond the expenditure of more funds for greater quantities of traditional services with larger numbers of traditional personnel, and beyond attempts to reconstruct persons receiving services so that they can be fitted into old modes of treatment which have passed the test of time if not of evaluation. Although there is a failure in the allocation of services, increased and improved distribution of services as a major goal will serve to

perpetuate a more significant area of failure, the failure to help man realize his humanity.

Working toward this goal is not an idealism inappropriate to the helping professions; it is, on the contrary, an example of the kind of help which values the individual in his efforts toward growth and self-actualization. Interest in the way the individual lives includes in its range of vision his transactions with persons around him, the world in which he dwells, and their impingement one upon the other. Such a sociopsychiatric orientation recognizes the need to maximize human potential and to encourage the entry into more productive social systems of larger numbers of people excluded because of factors such as psychiatric label, race, social, and economic position. It seems a relationship between efforts to aid individuals to change and planned social change as an intervention necessary to alter conditions in society detrimental to man's development. The helping process is viewed, not as one giving to another for altruism or control but as a process of assisting individuals and groups to mobilize their own strengths to move through increasingly productive states. In this view, the small group is con-

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sidered a vehicle offering individuals the opportunity to develop more effective interpersonal adaptations, to cope more successfully with the environment, and to be freer to move with greater power into other social systems.⁵

Inherent in the systems approach is the assumption that it is not the individual who has faltered but rather the systems in which he is embedded which have failed to sustain him and maximize his potential functioning. This is a departure from the traditional view that malfunction is almost entirely within the province of intrapsychic factors. Systems theory asserts that any subpart of the total society is an open social system, its boundaries determined by the relationships and patterns of behavior which carry out the continuing cycles of input-transformation-output. In short, society is viewed as a vast constellation of interlocking and interdependent subparts. Thus, to conceive of illness as a function of the individual personality is a telescopic view of man in his society.

Underlying the traditional definition of mental illness is the gross misconception that large segments of our society are expendable. The psychiatric labeling and rigid perceptions of deviance legitimizes the expendability of human potential. Too often those numbered among the castoffs are persons who are poor and black. Does not this thought call for a relooking at the process by which deviancy is defined? Is it possible that some of the behaviors identified as "crazy" are more truly healthy responses to the societal impositions placed upon alienated groups of people? Could it be that some overt aggressivity is not so much a function of developmental impulsivity but more an adaptive response to con-

flict imposed upon people from societal forces? In implementing treatment modalities which would embrace a systems approach, the focus must be upon increased functioning and the ability to assume new roles to fit varying social situations. One of the crucial questions in community mental health services is the articulation between a given agency's treatment goals and the realities of the social systems in which the patient must function. We might even ask how successful we, the professionals, have been in coping ourselves with some of the negative forces emanating from major social systems of the society in which we function.

In this context then, rehabilitation is viewed as the "reintegration of the individual into the community on the most efficient and useful level of adjustment possible."¹⁶ The verbalization of such a statement is new for many in the helping professions. Acceptance of a definition which uses words such as "reintegration" and "useful level of adjustment" may cause the caretakers to become more concerned with the functioning of the individual than with curing the underlying psychological disorder. But awareness of the ramifications involved in this concept of rehabilitation causes a broadening of the traditional focus of psychiatric professionals. The focus moves from psychiatric improvement alone (which usually means a diminution of symptomatology) to include the areas of vocational, educational, familial, sociotherapeutic, medical, and community involvement.¹¹ A program which claims to offer total rehabilitation must involve itself in each of these areas.

A key factor in developing and establishing a realistic rehabilitation approach lies in recognizing the fact that patients

generally return to communities in which they have spent most of their lives.⁴ For those persons returning to disadvantaged or ghetto communities, there is little chance of the community being able to reach out and contribute to their attempts to reenter. The community residents have their own daily fears—fears of succumbing to those powerful forces of society which tend to isolate, victimize, and render helpless persons living within the confines of low-income areas. Changes and innovative techniques must be developed to lessen the disequilibrium not only between the patient and his community but between the community and society as well.

INNOVATIONS IN REHABILITATIVE APPROACHES

The Harlem Rehabilitation Center has accepted the challenge of making the rehabilitation concept one which is viable for people of the black community. Within the center are three service programs: (1) The Psychiatric Rehabilitation Program, which has a sociotherapeutic orientation; (2) The Continuing Rehabilitation Program, with the major focus on resocialization; and (3) The Vocational Rehabilitation Program. The inclusion of these programs within one center allows for the utilization of the concept of graded stages of rehabilitation.

The implementation of underlying philosophy at Harlem Rehabilitation Center will be presented through examples drawn primarily from the Psychiatric Rehabilitation Program, the first to be developed and the one in which the elements of program operation have been most fully defined.

The therapeutic approach of the program is implemented through struc-

tured meetings (core group) and through adjustment activities (in which members and staff are grouped according to the activity). The communal and adjustment activities and the structured sociotherapeutic meetings have as their goals: social reeducation and the development of coping and social mastery skills through the use of a social situation in which newly learned behaviors can be tested; the development of the creative process; group relatedness, interdependency and, ultimately, autonomy of action; and the development of adaptive behavior at individual, interpersonal, and social levels.¹³

Group Meetings: With the above mentioned specific goals in mind, group meetings are used programmatically as vehicles for individual and group change. These include:

1. *Therapeutic Community Meeting*, held weekly, attended by all staff and patients. Its purpose is to provide a protective social situation in which the following behaviors can be learned by patients and staff: the development of a therapeutic community on the level of group, program, and center; open discussion between patients about intra- and intergroup patient problems; open discussion between patients and staff about common problems; the development of leadership behavior through identification with staff who act as role models; and the fostering of concern among the patients for each other. It shares with those employing the behavioristic focus the assumption that for persons with functioning problems, action and the behavior change must precede insight.¹

2. *Worker-Member Meeting*, a weekly meeting led by the paraprofessional Psychiatric Rehabilitation Workers, is

designed to develop overall program planning ability on the part of the staff and patients and to help patients develop group leadership through identification with the workers. Members discuss life and program problems, formulate their grievances, and develop plans for redressing these grievances and learn problem-solving techniques. This approach is based on the service principle that "Persons who have themselves somewhat successfully functioned in some of the social systems under consideration may be able to engage in helping transactions with those more damaged or less successful in their functioning."⁴ Both the patient identification with the paraprofessional staff member and the sharing of communication systems of workers and patient are seen as positive gains in the worker-patient relationship.^{2, 6}

3. Patient Member Meeting, held weekly by patient members alone. It is designed to promote patient leadership and independent functioning. Here they discuss plans and decisions which affect them as a group. Through this vehicle patients elect officers, develop group savings accounts, initiate program plans, and encourage and control member participation.

4. Discussion Group Meetings, designed to provide educational, social, and cultural enrichment, to aid in resocialization, and to stimulate pre-occupational interest and motivation. Among the topics covered are meal planning, nutrition, consumer education, money management, extermination of rats and roaches, rent control, legal aid, benefits from Welfare, Social Security, and Medicaid, housing, civil rights, black identity and history. The lack in social knowledge apparent in the population we serve

necessitates these sessions. Through them and accompanying planned community encounters, attempts are made to stimulate patient initiative in joining community and social action groups.

Communal Activities, in which members are provided with an opportunity to test out behaviors and information which are learned in the four structured meetings. The various communal activities employed include: group lunches, group trips, group projects, open house, intergroup parties, group bank accounts, and resocialization activities. Each specific activity allows for its own group of behaviors, exemplified by the projects developed by members. These allow them an opportunity to develop a profit-making venture under their own leadership. They use both creativity and problem-solving devices to do their project selection and use compromise and cooperation to accomplish their goal. The success that usually occurs helps to increase feelings of self-worth.

Community-related resocialization activities have included church programs, voter registration drives, the Medicaid Town Meeting, and the Poor People's Campaign locally and in Washington, D. C. These kinds of activities relate members to the nonpatient world and afford an area for them to begin to reintegrate themselves into community life and become acquainted with current social issues through participation. From this it is anticipated that there will develop group and later independent social action.

Adjustment Activities, which make use of the small group vehicle, add a dimension to the daily living activities. In each the patients participate in a variety of experiences which allow the exploration of skill potentials, general

work attitudes and interest, and interpersonal methods of relating and coping. Each activity is directly related to the acquisition of skills that can be incorporated into the daily lives of patients, but which can also be a basis for further prevocational rehabilitation. These areas include essential skills, sewing, culinary arts, and crafts and maintenance. The concern about rehabilitative components and the balance among them is reflected in continuing modification of original ideas and programing as attempts are made to relate the program to the realities of life experienced by the population.

Within the *Vocational Rehabilitation Program* the group focus is maintained but the weighting of services shifts to include prevocational evaluation, prevocational training, personal adjustment training, individual and group vocational counseling, community work placement, and job referral and placement. The vocational program incorporates two major elements: learning therapy and counseling. In the learning-therapeutic category, prevocational activities bring about a change in patterns and habits. These activities are a specialized extension of experiences that nonhandicapped people have, and it permits the client to have an opportunity to fail in an environment where the results of that failure are not catastrophic. In the counseling category, prevocational experience is a non-definitive part of the counseling process and the activities are selected as needed through counseling. The client is helped to integrate that which he learns or experiences when in the prevocational unit.¹⁴

The coordinator of vocational services, a vocational rehabilitation coun-

selor, has stressed the importance of prevocational evaluation as the first phase in the vocational rehabilitative process. The goal here is to determine potential and directions for training from an occupational aptitude pattern gained from the use of a series of work samples.¹⁴

Evaluation is followed by an extended phase of prevocational training. Components of this are clerical, cafeteria, manual skills, messenger, and porter training. Future plans include the development of a hospital work program. The ultimate goal of this training is to effect direct placement in entry level positions in competitive industry or a more advanced training program.

The client group adjustment meetings held weekly are an integral part of the rehabilitative process. They include: (1) Therapeutic Community Meeting, in which all clients and staff assigned to the program participate; (2) World of Work Meeting led by the vocational rehabilitation counselor; and (3) Client-Worker Meeting, led by the paraprofessional workers assigned to the Vocational Rehabilitation Program.

We recognize the additional burdens that a person with mental illness must face in returning to the labor market in a community where unemployment is extremely high. Plans are now being made to develop work stations in places where a cooperative relationship with employers has been established. The clients will be accompanied and assisted by paraprofessional vocational workers in their initial placement periods. This approach is to be used not only to develop programs within the community but also to include outside agencies and industrial contacts. This will begin to

lay the groundwork for the development of self-sustaining industrial units within the community. As persons move to this step in their rehabilitation, continuous additional places will be opened within center programs for other persons recently discharged from psychiatric hospitals.

The Continuing Rehabilitation Program is designed for those who either cannot tolerate or do not need the many-faceted approach of the other two programs. One group which meets three half-days weekly has as its central focus resocialization and transactional relationships. It resembles a group described by June Jackson Christmas² in the development phases through which it has gone from pseudo-socialization to peer-related autonomous action which includes work-for-pay activity. This group movement occurred in approximately five months. The experiences which group members acquired through participation in one of the more intensive programs and the skills and sophistication developed by the paraprofessional psychiatric rehabilitative technician who is in charge of the program may account for the swiftness of this development.

A monthly medication group is held in this program with patients who no longer participate in other programs. During this meeting, discussion takes place concerning attitudes and problems in the patients' general life which may give indications for maintenance or modification of drug therapy. Medical and social problems are picked up by the psychiatric rehabilitation technician and the health service worker, a Psychiatric Rehabilitation Worker, who serves as co-therapist with the divisional psychiatrist.

UTILIZATION OF THE TEAM APPROACH

The health, social, and community services which are an integral part of the rehabilitative process are also group focused. The expansion of these services relates to the multiple needs of clients and the relatedness of many of the social systems to which they belong.

The total clinical and social services staff (professional and paraprofessional) are team participants in the handling of crises situations. This team approach has led to the successful avoidance of many crises.

When need for psychiatric treatment or help has been recognized by any member of the team, the team is alerted and measures taken to assist the patient in the period of adjustment. This has varied from reassurance when a patient reacted in an angry abusive manner with feelings of being abandoned by transfer to another service agency, to intervention at times of suicidal preoccupation, disintegration, or an upsurge in psychopathological phenomena. Intervention includes group support, individual and multiple therapist counseling (the Psychiatric Rehabilitation Worker and professional staff), modification of the program to fit individual needs during the critical period, hospitalization in the Harlem Hospital inpatient service for short-term care, and intervention with families to work through the crisis situation.

Medication of clients is handled by the divisional psychiatrist during the Therapeutic Community Meeting on a once-monthly basis. Both clients and staff discuss the functioning of the client through this self- and group-evaluation period, and the client is both aided in

his appraisal of his own functioning and supported in his attempts at growth. The confrontation which takes place in these sessions is viewed as a social learning experience for the participants.

Additionally, an hour is set aside weekly when the psychiatrist will prescribe medication for all clients unable to attend the regular Therapeutic Community Meeting. The paraprofessional health service worker participates at these times both in the preparation for the group medication and the counseling and instruction of the client.

Health and case service workers share the responsibility of helping the client recognize and cope with problems outside the Rehabilitation Center. Thus, the health service worker, while insuring that the client receives proper and complete health care within existing community facilities, will often need to be the advocate until this role can be assumed by the client himself.

Services to families and other significant persons are seen as the combined responsibility of health services and social and community services, requiring joint planning. Contacts with families have been broadened since the initiation of the Family Members Meeting. These monthly meetings are led jointly by the supervisor of health services, a psychiatric nurse, and a social worker, with the participation of paraprofessional rehabilitation workers. The purposes of this meeting are to assist family members in exploring their health needs; to counsel and guide families in their own problems and concerns, as well as those they express which involve the identified sick member; to explore their concerns about mental illness and provide relevant information; and to give health, rehabilitation, and community information

which can be useful for themselves and others. Expansion of family services is planned, to include family diagnostic studies, family therapy, and family counseling groups.

RELATEDNESS TO THE COMMUNITY

Through the community and case service workers we have made consistent and productive contacts with public and private facilities and formal and informal groups. We see our work within the community as particularly relevant to the goal of serving as a force for individual, group, and social change.

It is the responsibility of persons providing rehabilitation services to assist in changing community conditions to which patients must return so that they can usefully apply the capacities they have developed. To the extent that treatment centers fail in this task, they indirectly contribute to the waste of human lives. Certainly, if discharged Peace Corps enrollees need special attention to cope with their reentry problems, the discharged mentally ill patient of the ghetto should not be required to settle for less. An effective community-based treatment facility transforms a system of patient rehabilitation to a dual system of patient rehabilitation plus community rehabilitation. The extent and types of services rendered by the staff vary widely depending mostly upon the needs expressed by the residents of the community. Services provided on an "expressed need" basis involves an expansion of services which broadens the basic scope of a rehabilitation program.

A community-based rehabilitation program cannot and really should not attempt to solve all of the social and economic problems of a community. However, it does have a key role to play

in the process. An important first step is to assume a posture of commitment and concern for relevant community issues. Included among the more detailed things such a program can do at the resident level are:

1. Broaden the opportunity for increased participation by residents in the community for their betterment as efforts are made to improve the conditions for individual patients. This may begin by simply inviting residents of the community to meetings within the center to share in patient and staff discussions around common problems of daily living and seek solutions together.

2. Educate community residents in methods to take full advantage of existing community and citywide resources. Throughout our city, for example, are many beckoning human service agencies. However, their designs are totally puzzling and frustrating to the people whom they purport to serve. The know-how acquired by the staff for individual patients must be passed on to the residents to foster in them the power of effectively using resources.

In order to play its role effectively the Harlem Rehabilitation Center had to reflect concern about the local conditions and an interest in doing something about them. The block in which we are located contains massive problems beyond the scope of agency staff to handle and certainly beyond that of individual residents. Combined and coordinated efforts on the part of staff and community, however, are beginning to make for a somewhat different picture. From the very beginning all staff made an effort to make our presence in the area felt by friendly greetings and talking with the neighborhood people who sat on stoops, stood on the corners

and in doorways. This attempt was supplemented by the fact that some of our patients lived in the block.

Because of the constant emergence of crisis situations, within six weeks the center had received a variety of requests for service. One such request came from a grandmother who was concerned about her daughter and grandchildren. They were victims of a fire which had left some 20-plus families destitute. Although the initial concern was about one family, brief exploration revealed several families completely disorganized and lacking information about available resources. The center responded to the request and assisted one family through the process of securing help from the Department of Welfare. Two of the people involved were given sufficient information and encouragement to assist the other families in making contacts in keeping with their needs. There was, of course, assurance that our staff remained available to assist.

Following this service many neighborhood residents began to visit the center. From the community worker's attempt to help them a new need was visualized—the people in the block felt (and were in fact) isolated from the larger community (the local antipoverty agency, the United Block Associations, etc). and intimidated by discrimination within and outside the community. The center played a vital role in the formation of a block association and assumed the responsibility for providing a facility where meetings could be held; guidance and consultation in organizing the association; assistance to the potential community leaders in developing techniques for their assigned roles as chairman, secretary, etc.; assistance in devising ways to mobilize all the local residents and in-

volve other agencies and groups servicing the general community; and assistance in developing strategic methods and support as needs arose to fight for community improvement whether it was fighting with landlords or city agencies.

To improve environmental circumstances the basic tool is, of course, human power. A great deal of human energy is locked into the ghettos of urban inner cities, virtually unable to make its presence felt—except by socially unacceptable behavior.¹⁰

Our limited experience in working with the residents of our block has made for a more aggressive program in terms of dealing with problems at both the group and individual level. The people organizing and helping us to meet the challenge of a hostile power structure are usually so-called "societal misfits." Their behavior exhibits those symptoms which often lead to imprisonment, mental institutions, and even death. Yet they have been able to marshal sufficient strength to meet regularly and discuss common problems.

We have begun to realize that many of the residents of the block share a tremendous sense of urgency to do something about their life situation, a questioning of established values, and a strong desire for participation and involvement. One of the most important aspects of our mutual efforts with the community residents is the development of potential community leaders (a necessary first step in institution building). As the opportunity presents itself each resident is helped to apply his knowledge to the solution of a problem facing a neighbor, one way of assisting the residents to become self-sufficient and independent.

One of the most useful advantages of a comprehensive community-based rehabilitation program is that it attempts to correct the inadequacies of the existing community facilities by working closely with them to provide coordination of services. Agencies have been encouraged to develop appropriate programs and to include certain rehabilitated patients in general agency activities (i.e. Goodwill Industries, Harlem Hospital Center, YMCA). Thus as patients benefit from participation in the rehabilitative program, there has been an opportunity for them to move into community-sponsored programs at a level commensurate with their capabilities and needs. Systematic application of the need-benefit principle is essential to meaningful rehabilitation. To implement this principle, the establishment and maintenance of a working relationship between the center's staff and all community placement and service facilities is required.

Existing community facilities have needed mental health consultation in order to develop new resources and make appropriate referrals. Community involvement as described here has not only stimulated the interest and development of other resources but has helped patients and their families mobilize themselves to make better use of psychiatric services and other community resources. Participation in patient and staff meetings by persons from the community, of course, has served to further this interchange and interaction.

Mental health education has been conducted through use of the professional and paraprofessional staff. The use of experience and skillful paraprofessionals in mental health education has led to more effective contact with

their peers in the community. This was accomplished, in part, by the use of members of our paraprofessional staff as trainees and consultants in other community programs.

Finally, the community-based rehabilitation center has begun to show significant effect upon the production of positive community leadership, attitudes, and actions.

As an outgrowth of the reciprocal relationships, the center has developed mutual services with many community agencies. These have included:

Employment: Community agencies have served as a major source of recruitment, especially for paraprofessional staff. The center has given full-time employment for formerly unemployed community residents, on-the-job training, learning by doing under close and helpful supervision.

Training: Agencies have paid local people while they were trained and utilized, and the center has provided the field placement and training resource for these agencies.

Consultation: The center has provided trained staff available to serve as trainers or program participants in community training programs using a new realistic approach to problems of low-income communities. While doing this, the community becomes a supplemental training resource for paraprofessional staff providing opportunities for them to broaden experiences and undertake special activities as community trainers, neighborhood workshop consultants, etc.

Vocational Rehabilitation: While the center offers a constructive training experience which improves existing vocational skills and develops new ones for former residents of the community, the community itself becomes a source of

job placements for previously unemployed patient-group members.

Community Action: A constant interplay exists between stimulating and interesting clients and staff in community activities and the center's utilization of community action groups as a source of additional patient-advocates in regard to negative aspects of community living.

As suggested by the range of services discussed, a comprehensive and therapeutic approach to the psychopathology of ghetto residents utilizing all of the existing resources is being attempted by the Harlem Rehabilitation Center. Its conceptualization of the ghetto community is that it is a vibrant entity, which if properly utilized can enhance the total rehabilitation process.

PROBLEMS AND CONSIDERATIONS

To strengthen the therapeutic community orientation of the center we are trying to develop some type of system which will allow for decision-making power by both clients and paraprofessional workers at all levels of the center power structure. What form this power might take has not been fully decided. Presently we are still working through the variety of ambivalences expressed or felt among clients and staff, such as "How can patients have voting power in the center? After all, they're sick. Patients do not have the knowledge to make decisions which will alter their treatment plan." "We, the patients, are reluctant to give up our role." "We, the workers, are not quite sure of our role as the bridge between client and professional. Will formalized power alter our informal power system? What added responsibility will it give us?"

Like Albert Camus' Sisyphus, we are

ceaselessly rolling our rock to the top of the mountain and towards a viable participatory democracy.

The vocational component which has been developed within the center presents another challenge to the articulation of treatment goals and the forces of social systems in which the client is embedded. We are facing the problems of exploring ways to apply principles of the therapeutic community to a business oriented subsystem of our treatment program—the vocational program. Do therapeutic community concepts lend themselves to a vocational concern? We would like to think so! What modifications, if any, are necessary to effectively utilize these principles in a work setting?

The concrete concern of those who are attempting to coordinate the psychiatric and vocational programs has been to determine how the particular activities to which the client is exposed in the former program are related to vocational training and in what ways they tap his vocational potential. Does the manner in which work activities are presented in a psychiatric program impede or cloud the issues of patient progress, rather than support movement into the next rehabilitative stage? Here we are concerned about the beginning work habits that are fostered and the introduction and utilization of activities in a graduated manner so that the clients' skills, stress capacity, and frustration tolerance can be evaluated. Does the proper manner of doing things, in vocational terms, conflict with the short-term objectives of the clinical program? For example, work with a group of schizophrenic patients, who are encouraged to plan and implement a group project, may not proceed in an orderly manner with a clear understanding of the rudimental business concepts

involved, yet they may be making great strides in the improvement of social mastery skills, involving competition, compromise, cooperation, and collaboration.

On the other hand, how long can the ignoring of vocational concepts be allowed without causing confusion for staff and clients? We experienced this when a group of clients, who had been together for some time and had passed through several identifiable steps in the resocialization process, were making boutique items for sale and running a snack bar. Many of the clinical staff shared the hope that this was the beginning of a small business for the group. After an evaluation by our vocational staff, we had the painful revelation that this group had neither an adequate foundation of basic work skills nor beginning knowledge of principles necessary for the running of a business. And to compound the problem, the staff working with them lacked this business knowledge too.

These experiences precipitated a rather agonizing reappraisal of the interrelationships of clinical and vocational rehabilitation. Clinicians are attempting to analyze their degree of true commitment to the vocational component. Heated discussions have reflected both professional biases and knowledge vacuums between these two rehabilitation orientations. The clinicians were stating that the initial efforts to help the client in improving his environmental mastery require focusing on his ability to work through relationship problems. The logic used is that by working through areas of conflict seen in observable behavior in his transactional relationships, the client can be helped in his development of alternate problem-solving be-

haviors and in his obtainment of specific knowledge about the social system in which they occur. At this point the person may be ready for vocational training.

Vocational experts, on the other hand, state that clinicians have no objective methods for making such a judgment and tended to underrate the client's ability to function in a socially defined work role. Indeed, with the clinician's emphasis on illness he might mask an investment in keeping the client dependent for an unnecessarily extended period.

Such arguments will continue, with "the right" being on both sides, until we have developed the tools for diagnosing the level of adaptation at which the individual comes to us in each of the critical areas involved in rehabilitation, and for evaluating the individual's potential for optimal functioning.¹²

This problem is compounded by the disagreement as to how vocational concepts should be employed in a black community. Should the traditional approaches be transferred intact to this community, on the basis that locale and the attitude of those running the programs have caused defeat for black people in the past? Or is there a need to alter the basic approach, since the approach itself may be inadequate to meet the needs of the client?

The measure of success is not how well a client is able to participate in decision-making or assert his rights in a rehabilitation center geared to fostering behavior which allows him to feel a spark of human dignity; rather it is based on how well the client can navigate in a world where assertiveness is seen as hostile aggression and compliance to a destructive system is seen as cooperative-

ness. Thus, while fostering the development of this microcosm of society and still attempting to relate it meaningfully to the outer world, we are asking: "Is there a need to modify life styles of the staff involved, both professional and paraprofessional?" "How can we make maximal use of the coping devices well known to the indigenous population, which are brought to the work situation by this new worker?"

Professional workers, who are generally drawn from the middle class and employ an accommodative life style, seem to be most comfortable in program development, while the paraprofessional worker who tends to use an action-oriented life style can more readily make use of the agitation or adversary models.

To both help people bring about necessary societal changes and at the same time give them the necessary skills to cope with the residuals of change, we must develop and implement an operational framework which encompasses the full range of social action strategies. If we can make some beginnings in understanding the dimensions involved in implementation of services of a pragmatic service model and in the utilization of personnel, we will have made a valuable contribution. The development of other groups to work along side those already in the human service field is imperative. But when working with these new groups, how do we truly capitalize on what they bring?

We say that the paraprofessional brings a capacity for empathizing with the client population, but how do we utilize this capacity and preserve it? Numerous studies have shown that the capacity for empathy is inversely related to the amount of education of the individual. Thus, nurses, for example, may

have less empathy at the end of a psychiatric nursing course than at the beginning. The professional dilemma is how to effectively educate without destroying all remnants of human feeling, and how to overcome some of the road blocks that professionalism has put in the way of service.

Specialization in professions, although necessary, has brought with it various evils. Because of long and arduous periods of specialized training, the helping person's commitment frequently goes to the profession and its survival and not to the community it theoretically exists to serve. His view of himself as the expert causes an automatic placement of the client in a dependent, rigid, formal relationship.

When the ingredients of one's effectiveness are unclear with respect to the balance of personal characteristics versus the training requirements, members of a profession need the protection of professional identity even more. They may then make greater attempts to establish their claims to the uniqueness of certain activities and functions, claiming them as their sole property.

In glorifying his own area of expertise, each professional tends to devalue areas for which he has no ready answers. Thus the medical professional may devalue problems of income, housing, imposed dependency. Indeed, he may see himself as the center of the universe around which the patient revolves, rather than seeing the client as the center and the service he offers as only one of a multitude needed or utilized by the client.

The focus on fragmentation and specialization so lauded by the professionals is alien to the client and perhaps destructive to service. The low-income client likes his helping person to be more

wholistic in his approach, more informal and person-centered in his relationship. And he prefers things, be they remedies or directions, to be given in a structured, organized fashion. He also prefers action to talking or passive acceptance.

The paraprofessional worker becomes essential, then, because of his stress on activity and direct, aggressive problem-solving. He can, with ease, share of himself with the client, perhaps telling his very personal life experiences, yet can help focus the client on the doing of concrete tasks.

Through the identification process that the client develops with the paraprofessional Psychiatric Rehabilitation Worker, it is hypothesized that accelerated, increased functioning will occur, that the action orientation and conflict model employed by the workers will affect the passivity seen in the client. The development of the habits of labeling social events, seeing causal sequences, and understanding his own response, all activities related to cognitive growth, are seen as resulting from the identification of the patient with the helping person.

This does not mean that personnel problems with the paraprofessional groups are not encountered. For this group it may be that training may serve as a substitute for treatment⁶ and thus may play an important part in their own rehabilitative process. This staff rehabilitation is twofold, for both paraprofessional and professional, *and is not infrequently shattering to the professional*. Example: We as clinicians, often pride ourselves on our understanding of the concept of conflict. Conflict, we say, is a valuable type of interaction in a group, since it makes the members take themselves seriously as people, and can

help develop group cohesion. In the course of ironing out the conflicts, members increase their self-confidence and communication skills—qualities which may be deficient in those suffering from social injustices. We equate this with working through problems with authority and see it as a significant way to increase one's coping repertoire. Many see this as an underlying principle in sensitivity training groups and group therapy. But, what if this "working through" is not confined to the sensitivity training session, and if the authority figures being challenged are you, and, since you have developed at least minimal open communication, the workers feel free to let you know exactly what they think!

Some of their views may be: You are "Uncle Toms!" You tell us to be proud to be black, yet you bow and scrape when rich, white visitors appear! You tell us that what we and our ideas are of value, yet when we offer them you do not accept them, or you alter them so they are no longer ours! You told us you valued the ways that we have developed for survival, then you label them as "hustler" characteristics and make us conform to middle-class ways—like coming to work on time, meeting deadlines with work assignments, placing limits on our approaches to problems! You tell us conform! Adapt! You say you need us, but you're still running the show! You are messing us up! Now that we are part of the establishment, with whom do we identify? Now with you, and not with those in the street!

The handling of hostility, according to Karen Horney, is the central problem of middle-class society. Our traditional mechanism for handling it is covertly, through accommodation, adjustment, adaptation to what we say are the reali-

ties of the situation. We use the civilized strategies of adversary and redress, and develop programs.⁸ But whatever we do, we do not bite the hand that feeds us!

So when confronted with a group that is more overt with its hostility, we professionals are often stymied. Yet we know that to develop the value of independent action, both workers and patients need to deal openly with hostility within the social systems in which they find themselves. And to maintain a healthy, viable organization, avenues must be developed for absorbing and channeling this hostility so that it can be turned into constructive action.

Not a very quiet life! But, perhaps a healthy one. And one where all may modify their life styles. After all, there may be untried alternatives between giving the red carpet treatment to someone from whom you are seeking money yet resent and beating up someone who has done you wrong!

Again, we are made constantly aware of the scars which result from disadvantaged social status when working with staff drawn from the community. We say that the worker shares life experiences and therefore is valuable in the rehabilitative process of the patient. What happens, then, when these life experiences, which we say are of value, get in the way of work? What happens, say, when the worker has not acquired the tidy value of saving and paying essential bills, and gets a dispossession notice, when an addict boy friend appears at work ready to beat up the girlfriend, when the probation officer appears for a report? What happens to middle-class professionals when faced with having to curb "numbers running" on the premises, or when a worker wants help in handling an addict son? These life problems tend

to effect punctuality and attendance. The workers tend to have more real concerns about being robbed, and beaten, having boilers that blow-up, and ceilings that leak!

In our days of greater naïveté, we felt that by giving to the worker a sense of value and self-worth, good training and supervision, we would see that he could do what others said was impossible. We still believe this today, but now we can also see that with the magnitude of the realistic problems of the worker, individual counseling must become an integral part of the work situation. The professional assumption that personal problems should not spill over into the work situation is questionable in a program which claims to maximize the potentials of the paraprofessionals.

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3. The View of the Paraprofessional

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The question has been asked time and time again. "What am I?" The poor black man has asked other questions. "Why can't I do the same things as poor whites? We fight and die for this country. Why can't I, a poor black man, be treated the same and have the same opportunity as the poor white man?" "Why am I deprived of an education?" "What is liberty?" "What is the qualification of a man in the United States of America?"

The Negro man is walking out on his family, leaving them because of the pressures that he has in his home and on his job as well as in his community. A man may feel that the Welfare could do more for his family than he can do when he can't find a decent job. With him out of the picture, his family might have the possibility to live much better, because the little money he is making is not enough to support his family. He can no longer take the pressure; he does feel concern for his kids and love for his wife so he doesn't want to leave. He wants to maintain manhood, but he has been struck so many times in so many different ways that he can no longer exist with his family. Everything that he does is being destroyed; his women are being taken away from him; his jobs are being taken away from him so he no longer considers himself a man because

he doesn't have the opportunity. His woman is dominating him. So he just stays out of the house. He says, "Well, I have to live by myself, so I will live by myself."

Many of the people that come to the Harlem Rehabilitation Center have felt the same way and have had lives like this. They could no longer take the pressure. They have become mentally ill. Many of us have had some of the same experiences, but have been able to cope a little better. We got involved in the Center knowing we may be able to help others as well as ourselves. We are Psychiatric Rehabilitation Workers—Ruth Wade is a Community Worker; Garland Jordan is a Case Service Worker; and George Myers is an Activity Worker.

The reason we were hired from the streets of Harlem by the Harlem Rehabilitation Center was because we had lived, seen, and experienced the same pressures as the patients. Because of this, we could speak on the same level as the patient and gain his or her trust. The professional tends to intellectualize, which is above the level of the mental patient. On the other hand, the paraprofessional is at their level and talks to them the way that it is. The professional in most cases cannot gain their confidence because they represent suspicion

MISS WADE is a Psychiatric Case Worker (Community), MR. JORDAN is a Psychiatric Case Worker (Case Service), and MR. MYERS is a Psychiatric Case Worker (Socio-Therapeutic Activities) at the Harlem Rehabilitation Center.

to the patient of not being released from an institution or to be committed again. By combining the efforts of the professional and paraprofessional, information gained by the paraprofessional is of most value to the professional, who would not have gathered this information because of the thinking of the patient. As an example, even in general conversation a patient will agree with the professionals so that the patient will be on the side of the professional and will not get any bad reports, which is being passive to authority—and information is held back that would be of benefit to the patient.

In the Harlem Rehabilitation Center, we call our patients "Members" so that they do not feel as if they were in a hospital or an institution. A regular Member-Worker Meeting is attended by all the Members and Rehabilitation Workers. Problems are discussed and solutions are reached together. In a Therapeutic Community Meeting, the Rehabilitation Workers, the clinical service supervisor, and the case service supervisor discuss plans that have been suggested in the Member-Worker Meeting and how best to approach them. We also discuss Members' problems that have arisen, so that a recommendation can be made in the Members' best interest. In the beginning, it was thought by the professionals that if we kept one-third of our Members, we would be grateful. At this time it is just the opposite: only one-third do *not* attend the program regularly. We have had our difficulties with Members and among ourselves, but we are aging with the program and the vintage is tasty.

TRAINING

Nine men and five women, all residents of Harlem, Bronx, and Brooklyn slum areas, reported on June 1, 1967

to be trained as Psychiatric Rehabilitation Workers. Seven hours a day on a five-day-week basis for four weeks we were given intensive training in Principles of Rehabilitation, Socio-Psychiatric Therapy, and Qualities and Characteristics of Leadership Abilities by the director of our program. Case Service Techniques, including home visits, was given by the supervisor of social work. We were instructed in how to ask questions of the patient and the patient's family so that we would not be prying yet be abreast of the patient's home environment and be able to assist. The coordinator of clinical activities conducted training in Group Activities Techniques. The practical nurse in our program explained various types of psychiatric medication, the medicines most used by our patients such as thorazine and stelazine. We were informed that medication was issued by doctor's prescription only and to be taken as prescribed. No one except the doctor prescribed medication for the patient. Not even an aspirin is given to any patient by the paraprofessionals.

All of this training was in depth and extremely educational. This new knowledge broadened our horizon, not only as Psychiatric Rehabilitation Workers but as individuals. Due to our lack of knowledge about mental illness, it was necessary for the trainees to take many notes. These notes enabled us to study at home. With our notes, we could practice saying and utilizing the new words. Words like "sociotherapeutic," "community resources," and "helping process." Statements like "Your life experiences could be a supportive factor to the person on the road to rehabilitation." The term "therapeutic community within and out of the building." All of these were used by the director and other staff. Situa-

tions that had occurred in our lives were seen in a different light as we were able to find out that many people shared similar experiences. We were able to apply much of our training to our daily activities. These notes helped us to adjust to the attitudes and behavior of the patients.

We were told to ask questions at all times. We were told to ask for definitions of words we did not understand. The director gets to the nitty gritty. We were told that an attempt to start promptly would be made. We were requested to use our appointment books. We liked this entire approach to training.

The indigenous fourteen entered the job with a jargon of their own. The professionals had a lexicon that was foreign to us. However, this whole training process developed smooth communication. We each learned the language of the other. It wasn't long before the professionals could shift to our level of communication. Without the flicker of an eye, if a paraprofessional seemed to be not paying attention to instructions, "Come out of your bag" rolling off the tongue of the coordinator of social work brought the guilty trainee's attention back to the topic under discussion.

ASSIGNMENTS

To be rehabilitated, Members need many different kinds of service from Psychiatric Rehabilitation Workers. Home visits are a vital part of finding out what a Member is in need of. A closeness that many Members had not experienced before opens new avenues for the Case Service Worker to probe for more information that the Member will now give to you more freely. Following through and acquiring their needs, gains the confidence of the Members, shows them you really are on his or her side. We try not to have them depend on us

too strongly because we want them to learn to do these things for themselves. Members who did not know how to come to our program were taught how to come by themselves by the Case Service Worker who is assigned to them, by giving them the name of the street, showing the landmarks where to get off the buses. None of our Members need that help anymore. Some go to places that they wouldn't dare go alone. They are conquering fears of inferiority and talking up for themselves. When you see the changes in a Member for the better, there is a glad feeling within yourself.

Most of our patients are on Welfare and do not know that they are not getting their needs, such as winter and summer clothing, things for the household, and clothing for the children. They live in houses that are and should be condemned. Some are living in small apartments that are too small for the amount of people living there. The Community Worker tries to move them to better living conditions. Ruth Wade got the assignment of Community Worker in our group. As a part of her duties as Community Worker, she took several of the patients to Welfare Centers to make application for Welfare. At first it was a rather slow process. The patient and Miss Wade would wait for an hour in a line before reaching the receptionist desk. They would receive a number and wait two hours or more to be called. For any person, particularly one with a mental problem, the waiting becomes an ordeal of torture. The Case Service Workers would hear the patients telling each other that they would rather suffer without the financial assistance than go through this degrading experience.

It reached the point that Ruth Wade could not see this continue to happen to our patients. Therefore, when she es-

corted Mrs. J. to the Welfare Center, she used what she calls a *positive approach*. She tells the story herself:

"Mrs. J. and I arrived early (a trick of the trade); we were fourth in line. Mrs. J. had prepared herself for this embarrassing situation she had heard others discuss. Not wanting Mrs. J. to suffer this indignity, I passed the letter of introduction to the young lady at the desk. She casually glanced at the letter as she reached for a number, I said, 'Young lady, I am the Community Worker from the Division of Rehabilitation of Harlem Hospital.' That did it! She looked up at us, my paraprofessional tone of voice let her know that Mrs. J. and I had no intentions of waiting the rest of the day for a service that could be dispensed in a very short while. While Mrs. J.'s apprehension disappeared the receptionist smiled and escorted us to an Intake desk. She took the seat at the desk and with extreme courtesy started asking questions that would expedite Mrs. J.'s case and eliminate another visit. In the past, I had made two visits to accomplish this. The red carpet treatment was offered Mrs. J. and I all the way. A Case Worker from the Department of Welfare visited Mrs. J. in record time. Her first check arrived within several days."

Our training has taught us to "get around the run-around."

The Case Service Workers in their daily relationship with the patient discover ever-increasing needs of the patient. In some incidents, the Case Service Worker did not know that the need could be met. A diligent Community Worker can discover existing resources to meet these needs. If the needed resource is not in our community, it is then listed as something which should be brought in or established.

One of the women of the block that our Center is in is a wino. She has been for many years. Today she is chairman of that block association. The block association was organized right in our Center. The Center is open Wednesday nights for their meetings. We have helped the concerned residents organize. The agenda of the meetings are focused on the betterment of the block and the community. The entire staff, professional and paraprofessional, are involved in the 128th Street Block Association. We are ready to picket, paint, pass out bulletins, work on voter registration, and I guess we would throw bricks if it ever comes to that.

The wino chairlady has been motivated into some real constructive action. She can spell "psychiatric rehabilitation" and defines our aims and goals as well as anyone of our professional or paraprofessional staff. She identifies with us. She has pride and she is recognized by all of the people now. You see, she is now a friend and associate of our director and the rest of us. Our staff room is open for her use as she has to help prepare the minutes of the last meeting, get the agenda for the next meeting set up, and help get out letters inviting guest speakers. She also interviews her neighbors and tenants in need of service.

When we first noticed this woman she was always intoxicated, stone drunk. She still drinks, but nothing like she used to. Not a spoon of medicine was given, either. When we caught her a little sober (out of her cups), we'd just plain talk to her. Well knowing ourselves, we were willing to throw ourselves into a situation that required this line of approach: "We are black, we're proud of it. We've got to let the world know we are proud of it, and we need you to help us. You

have something to offer our cause. You're a real worker when you are sober." Then when the coordinator of social service and the social worker offered their hands, they sat down with this woman, she knew we all cared. That made the difference! Community persons are instructed how to handle problems intelligently like trained social workers handle them. This wine-drinking woman solves a lot of the problems of her neighbors and other tenants. She makes trips to tell us what she has done, or seek a word of advice as she helps with problems of her neighbors.

The assistant to this wine-drinking woman is a drug addict. Before he attended our first community meeting, he had never been to one. He had never had turkey salad either. He had eaten turkey but not a salad. The neighborhood butcher, a Jewish owner, contributed the food for us to serve at our first community meeting. The word has gotten around that the Center is there and everyone wants to help, the butcher and the baker.

Since the community meetings have been held in the Center, this fellow, the drug addict, has cut his injections from five a day to one. He has a police record but he is an organizer. He attended a public meeting in one of our large churches as representative from our Center's block. He brought back a terrific report. He even met a lieutenant of the police force who had arrested him a few times. When he explained his new role to the police officer, they shook hands. This drug addict is standing tall again, he's a man, didn't the police officer shake his hand; oh yes, things have changed and are changing on 128th Street.

This program going on right under that drug addict's nose did more than hospitalization or incarceration could

ever do to bring him to the brink of realization that at the rate he was going, he might end up in a psychiatric ward. That man is aware—he has been made aware in a way he could understand and accept. He works to help others now. He understands the system, he knows it is geared against him. He began to have his eyes opened while eating turkey salad and drinking coffee at a long white table in the beautiful dining room of the Rehabilitation Center of Harlem Hospital's psychiatric program. With the proper guidance of a trained psychiatrist, a trained social worker, and a registered nurse, he had had contact with them through the Rehabilitation Workers and we are passing our training onto him. This uneducated fellow will not go about wildly shouting, "Black Power. Kill whitey!!" He is aware, but he was informed intelligently that Black Power is "Helping-Self Power," that "whitey" is his fellow man and together they must live and work and enjoy the fruits of this great country. I say this because if this man had become aware from the hot-head angle, he'd be ready to join the ever-growing crowd that is advocating violent revolution as a means of delivering the black race from their oppressors.

The Community Worker has helped compile for the use of the staff a resource file. At our finger tips are the names and telephone numbers of landlords, superintendents, and real estate agencies that are able to supply apartments and rooms to our Members. This is a very important part of our community involvement. The need for decent apartments and rooms can never be over-emphasized. It is enough to drive a member of the black race into a state of frustration trying to find a place to live that has the bare necessities of life as standard equipment. A bathtub with hot

and cold running water not in need of repair is so rare that it is like "extra accessory." The Urban League and the poverty programs are invaluable assistance in the area of housing.

The Activity Worker plays a major part in improving the patients' emotional adjustment, through adjustment activities. These are maintenance adjustment, arts and crafts adjustment, culinary arts adjustment, sewing adjustment, and clerical and basic literary skills. These are tools that Activity Workers use. The activities are therapeutic to patients. They bring out improved behaviors in a person and help him learn.

The job of the Activity Worker is to train people how to work, and teach them knowledge of how to do a job. We work with them, and show them what to do. An hour and a half in the morning we teach them maintenance skills, how to keep the Center in good condition, how to repair locks and repair furniture, and how to work different machines such as the projector. We teach them how to set up tables for guests and speakers. In the afternoons we teach them for three hours how to work on arts and crafts, how to take part in social activities. We have Workers who teach sewing, others who teach clerical and filing skills, and others who teach culinary arts and tutoring.

Activity Workers deal realistically with their patients' problems. The new trend in treating patients is to deal with basic issues. We try to give the patient the tools to better himself and to cope with his problems.

A NEW CAREER

In this field a new career has been born for any person that becomes involved in this program. The qualifications are that you have to be over 30

years of age, a high school "dropout," and living in the Harlem community. Dedication and willingness to learn are the key points for the Rehabilitation Worker. If you but realize what the future has in store for the man from the black community, many ambitions would be achieved that the individual could not see before. In our own case it seemed as though a new and brighter light was shining, all that was left for us to do is to move in that direction and many problems would be solved that never have been overcome in our environment.

We feel that we have arrived in the work we want to do because we are helping our own people, the "Black Man," to rise out of the slums and reach out to live a normal and more fruitful life. There is a superior feeling over one's old self in contrast to the new. Plans can now be made that we could not depend on before with a definite goal in mind. All it takes now is time and patience.

We work with groups of people to find out what a person is capable of doing. We see that they do an adequate amount of work to meet requirements. A group working together can successfully achieve more than a person can alone. They work together and communicate and exchange their thoughts and ideas. They try to develop a standard of skills. One group helps maintain the Center and keep it in condition. Doing physical activity, they get rid of tension, mental strain, and pressure. They get a sense of their own worth, self-respect, and self-esteem. It gives them a feeling of delight and they are proud of their self-preparation to make ready for a particular job. We reach this result by group action, by working together.

We try to help them become rehabilitated within themselves. We try to

help them to be able to face the world and make conditions better in their surroundings.

We try to build up their ability to work, and to be able to move forward in life. The activities that Members take part in will help give them knowledge and skills to survive and give them a better chance to meet these goals.

There are many black people that are the Walking Dead, dead in mind and spirit. We intend to bring them back to life and give them their souls. This is the aim of this Rehabilitation Center. There is a saying "The Weak Shall Perish and the Strong Shall Survive." In this black world of ours, the strong shall help the weak to function. This means that the next generation will function with a broader outlook.

We have heard the definition of Black Power from many sources and our impression leads us to think that most whites believe it is violence such as Stokeley Carmichael advocates. Then there was Martin Luther King who preached nonviolence from the black man. There are different degrees of Black Power. Working in this program is our way of showing Black Power, by helping the blacks who could not stand the stress of poverty. There is a quietness in our Black Power and the only noise that is heard from us is a deep sigh when one of our Members have to be recommitted. We deem this as our Black Power and dedicate ourselves to those that have not been as fortunate.

People wonder why the blacks are mad. We have been exploited in every conceivable way imagined, and have been used to propel other systems, be they left or right. We have been suppressed and now we want to lift our

heads and see better things. This is our Black Power and we love the thought that we are being instrumental in helping the "black community." We read literature of the whites and try to understand them. But do they read the blacks? We cannot believe they do, otherwise they would understand the black man and his anger in this case why he becomes a mental patient or ends up in jail. The family is left to fend for themselves, the children steal because there isn't enough to eat at home. The practice becomes easy when they aren't caught, and continues until they are. They walk streets in groups cursing and smoking and making obscene gestures to prove their manhood. The women are left with babies that do not have the same fathers. Dope is sold by them so that they can live better and faster. The ones that cannot accept the challenge of bettering their conditions end up in hospitals or in jail. The women use the church for an outlet on their emotions. This is the system that we are fighting and must continue until we have better black communities with better blacks who can help himself and his community.

In conclusion, we can sincerely say that the Rehabilitation Center is not just "in" the Harlem community, it is "a part" of the community.

Our indigenous co-workers and ourselves pray that our titles of Medical Expediter, Community Worker, Activity Worker, and Case Service Worker will not remain foreign words to the slum dwellers of these United States. We pray that these will be meaningful careers that a person can train for and live decently in a better community, in a better tomorrow that should have been yesterday.

SPECIAL REPORTS

THE LEGISLATIVE PROCESS IN CHANGING THERAPEUTIC ABORTION LAWS The Colorado Experience

Hon. Richard D. Lamm, Sam Downing, Jr., M.D., and Abraham Heller, M.D.

There is a growing belief in the United States generally, and in the medical professions specifically, that abortion is essentially a medical matter. However, each one of the 50 states has laws severely limiting the circumstances in which a doctor may perform abortions. Reform of these laws is a political product, purchased in the political marketplace, paid for with political dollars and sometimes political lives. This paper examines the successful progress of a liberalized law through the legislature of Colorado, the first of a growing number of states to pass abortion law reform.

The art of passing successful legislation is the practice of marshalling, and in some cases manufacturing, the necessary support for attainable goals. In a representative government, responding as it must to the wishes of the constituents, legislation is by necessity closely tied up with public opinion. Al Smith, one of the world's most practical

politicians, stated it thus: "A politician can't be so far ahead of the band he can't hear the music." It can be by definition no other way. It is this factor which now poses the greatest challenge to representative government. For the twentieth century, when the necessity for an extremely responsive government is acute, is also the time when the lag be-

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RICHARD LAMM is a Democratic member of the Colorado House of Representatives, who as a freshman member accomplished the political tour de force of putting through legislation which updated the 100-year-old Colorado law on therapeutic abortion. DR. DOWNING is an obstetrician-gynecologist in private practice in Denver and DR. HELLER is assistant director of the division of psychiatric services at Denver General Hospital.

tween the actual necessity and the political execution is the greatest. Despite times which demand we have vision to survive, no legislator who is too far out front of public opinion will survive politically.

The passage of Colorado's abortion reform law, the first and once most extensive in the United States, is an excellent case study in the advantages and limitations of the legislative process. Colorado's old law on abortion was put on the books while Colorado was still under a territorial legislature, and was atypical from its initiation. Colorado was one of the five states in the United States whose law went beyond permitting abortions only to save the life of the mother. Colorado's law included as grounds for abortion not only the need to save the life of the mother but also the need to save her "substantial risk of bodily harm." From all the statistics available, however, Colorado's number of abortions, even with the broader grounds, were similar to the national average. One of Denver's major hospitals had in the ten years preceding the passage of the new law performed only 49 abortions, an average of approximately five per year. This was a ratio of abortions to live births of 1 to 418, which compares with the average ratio in all U. S. hospitals as reported in the September 1960 *American Journal of Obstetrics and Gynecology*. The grounds given even for these few abortions were such that it is obvious that doctors were stretching the old law.

At the start of Colorado's 46th General Assembly in January 1967, a small ad hoc group of people met to discuss the possibility of changing Colorado's abortion law to bring it more in line with modern medical practice. The med-

ical profession was well represented in the group. The prevailing opinion at the meeting was one of pessimism, because it was our feeling that the attempt to change the law at that time would probably hurt more than help toward the eventual passage of a liberalizing law. There is nothing that so scares legislators collectively than to see a measure soundly defeated in the legislative process, and its proponent defeated at the polls. Timing is extremely important in the passing of successful legislation, and an ill-advised premature attempt often has the effect of substantially delaying a law's eventual passage.

We did, however, approach a few legislators for their reactions, and the more legislators we approached, the more a cautious optimism began to grow. It soon became apparent that in the last few years an immense change has taken place in public attitude toward the reproductive process. Two years before, Colorado had succeeded in passing, on a second attempt, a law which provided birth control information to indigent women. On the first attempt at that legislation the bill had never left committee, but upon its second introduction it passed by a fairly substantial margin. The support in public acceptance of that law had gone far to pave the way for abortion reform in the minds of legislators. The birth control law had been passed, put into operation, and forgotten. Most legislators were aware that in that case the storms of adverse reaction passed without raining retribution.

Certain issues lend themselves to partisan appeal, others are by nature nonpartisan. Abortion law reform is by its nature nonpartisan and our ad hoc committee worked hard to keep it that

way. Representative Carl Gustafson, a Republican from Denver, manifested a great interest in the legislation and agreed to be the prime co-sponsor along with myself (Rep. Lamm). Together we ascertained that on a bill which was bound to be this controversial it would be necessary to get 20 co-sponsors out of the 100 Colorado legislators to assure us that in the event of defeat we would at least set a base of support for its eventual passage. Together, Representative Gustafson and I approached our fellow legislators, starting with those whose backgrounds we suspected would be the most sympathetic toward this change. To our great surprise, virtually every legislator we approached not only agreed to put his name on the bill but manifested great enthusiasm. When we were finished quietly contacting the various legislators, we had a total of 53 co-sponsors, more than half in the House of Representatives and slightly less than half of the Senate.

At the initial stages of contacting the legislators, and when it was apparent that there was much more chance for successful passage of this legislation than we had originally anticipated, Rep. Gustafson and I called together the ad hoc committee to discuss the different possibilities of marshalling public opinion behind this law. We were well aware that the subject of legalized abortion, long taboo, would meet with quite stiff opposition, and we realized how important it was to have the various community opinion molders on the side of change. We invited clergymen who we knew were sympathetic to the law, along with a greater number of doctors, to serve both as our advisors and counselors. We immediately formed a committee of clergymen and charged it with the

express duty of contacting clergymen of all faiths and getting them to specifically endorse the new bill. We also set about the machinery of appearing before the Colorado Council of Churches in an attempt to get an endorsement from it. At the same time we charged the doctors with the duty of building an ad hoc medical committee of doctors whose names we could publicly use as endorsing the new legislation.

The next major goal decided upon by the steering committee was to approach the news media and seek their endorsement. The news media are the single most important factor in molding community opinion with regard to legislation. It was deemed imperative by our steering committee to at least negate opposition on the part of the press and if possible to seek specific endorsement of the bill from them. For this purpose a panel was formed consisting of Rep. Gustafson and myself representing the two political parties and a doctor and a minister representing their respective professions. The panel called upon all the major news media in the Denver area and explained to them our bill. Any medical questions were answered by the doctor, any moral qualms were soothed by the minister, any legislative questions were answered by the legislators. This effort proved immensely successful, and won us enthusiastic support during the legislative process in the form of three editorials by the state's most influential newspaper, *The Denver Post*.

With the co-sponsors added to the bill and the committee of doctors and clergymen rapidly growing, it but remained to ensure sympathetic committee assignments in the legislature. The leadership of both the House and the Senate can well defeat legislation by assigning it to

a committee where it knows it will be buried. We thus approached the leadership of both the House and the Senate and requested the bill's assignment to the Health and Welfare Committee, which we had previously ascertained to have both a sympathetic chairman and a majority favorable to this legislation. With the assurances from the leadership of the necessary committee assignment, the bill was introduced.

As expected, a storm of protest greeted the bill's introduction. *The Catholic Register* devoted a large percentage of its weekly issues for approximately six weeks to opposing the bill. Individual letters from all over Colorado, mostly in opposition, hit the desks of the legislators, and many of them were contacted individually by phone. The committee chairman in the House, where the bill was introduced, waited for the storm to pass over before calling hearings on the legislation. After approximately two weeks he called a public hearing on the bill, and we set to work to tailor our testimony in favor of the legislation. We determined to use as proponents of the legislation the most conservative and responsible people we had at our disposal. We consequently picked ministers, doctors, and lawyers who had not previously been involved in controversial legislation of any kind. We bent over backwards to show that responsible people were advocating this legislation. At the House committee hearing a total of 42 people testified, 23 in favor and 19 against. The bill was voted out of committee.

It was, however, necessary to make some legislative compromises. Even though Colorado's law on statutory rape set the age at 18, we found that there

was a great deal of cynicism regarding an age set this high. Consequently, on amendment to our abortion bill, we agreed to limit the ground of statutory rape to only those cases where the girl was under the age of 16. Additionally we accepted a change in the hospital committee provision from "majority" to "unanimous" consent of the hospital panel. We added that where a woman was living with her husband, the husband would have to sign a consent; and where a girl was under the age of 18, the parents would have to consent. However, we defeated all attempts to seriously amend the bill, and it left the committee with the new grounds for legal abortion intact: that a committee of doctors could approve an abortion if the woman's life was in danger, or if there was serious impairment of the mental or physical health of the woman, or if it was likely that the pregnancy would result in the birth of a child with grave and permanent physical deformity or mental retardation, or if the pregnancy was a result of rape (including statutory rape) or incest.

At this point it was felt necessary to help offset the heavily adverse mail which was coming to the legislators on the subject. To do this, we asked each of the 23 persons who testified in favor of the legislation to reduce their testimony to writing, and at the start of each legislative day we laid one or two copies of this testimony on the desks of all 100 legislators. Thus each day upon his desk, each legislator had some supporting testimony from a responsible source to help offset his adverse mail. We also reproduced some of the better articles on the subject and put them on the desks of all legislators. We attempted as best as pos-

sible to organize a general public campaign in favor of the bill, but concentrated on having doctors or ministers from each legislator's district contact him in support of the bill. It was our opinion that one letter from a doctor or minister supporting this bill, particularly if the legislators knew the person writing, was worth 20 adverse letters. This campaign proved to be very successful. The medical profession found its voice, and a long list of doctors subscribed to a list of proponents which we distributed widely.

We next anticipated what would be the principal amendments offered by the opposition to the bill, and then chose individual legislators to handle the opposition to the weakening amendments. Thus, the attempt to have a residency requirement inserted in the bill was opposed by a legislator who had heretofore not been particularly associated with the bill but whom we had briefed on all the arguments against the amendment. We did likewise with the other major weakening amendments, which included an attempt to require a court to decide, upon medical testimony, when an abortion should be allowed; an attempt to have an attorney appointed for the fetus; and attempts to strike down one by one each of the grounds specified. All major attempts at amending the bill on the floor of the House were eventually defeated and the bill was voted out of the House of Representatives, going to the Senate in substantially the same form as introduced and passed by the committee. The legislative history of the bill in the Senate was substantially the same as in the House. The bill passed—and after the House concurred in a minor amendment, the bill was sent to the governor for his signature.

It was extremely helpful to proponents of this legislation that all of those supporting the bill agreed upon the particular provisions at the outset, and none caused the added controversy of attempting to make it more liberal. All were agreed that the bill as introduced would be a substantial and advantageous reform of the existing abortion laws, and that we would only succeed if all proponents backed the same specific piece of legislation. The dichotomy existing between those favoring change in a state like California seemed to hinder the passage of any reform legislation at all.

It seems clear both from the polls and from practical experience that the public is still a long way from accepting an absence of all restriction whatsoever upon a doctor's authority to approve an abortion. It is still felt that the society through its laws has some special responsibility for dictating circumstances under which an abortion may be performed. It was easy in Colorado to argue that the moral issues raised by the opponents of this legislation had long been resolved in the United States, i.e. that under some circumstances any woman may obtain an abortion to protect herself. To those arguments that the new law allowed the "taking a life" and that thus the law was unconstitutional, we had the easy retort that no one had ever challenged the constitutionality of any of the other state abortion laws, including Colorado's, and that all we were doing was slightly expanding the categories under which an abortion could be obtained while at the same time tightening the circumstances under which it could be performed. When the question is put as merely a weighing of two rights—between the health and welfare of the mother and the potential human per-

sonality of the fetus—the public seems comfortable and satisfied. But if one articulates the question as whether or not a woman ought to have the unfettered right to control her reproduction, if necessary by abortion, public opinion answers a resounding “No.” To attempt legislation on such grounds now is to exceed the possible legislative objectives, and until community opinion moves further on this issue, to ensure defeat.

This does not mean, however, that proponents of change must accept legislation as the only method of changing the law. There is another governmental institution which has been a great force for social change, the judiciary. As was seen in *Brown v. Board of Education* (school desegregation) and *Griswold v. Connecticut* (birth control), it is often the courts which initiate social reforms. This alternative was carefully explored by a number of us before attempting the legislative route, and we found that there are a great number of analogies between the issues involved in *Griswold v. Connecticut* and those in abortion legislation. The reasoning of the U.S. Supreme Court in *Griswold* might well be broad enough to also declare unconstitutional the laws against abortion. Using the reasoning in *Griswold*, both statutes:

1. Are at war with currently accepted standards of medical practice.
2. Invade the sacred realm of marital privacy.
3. Force the birth of deformed children.
4. Are largely unenforced, but prosecution hangs like the sword of Damocles over the medical profession.
5. Result in discrimination against the lower economic groups.
6. Are in conflict with one of the world's

most critical problems, the population explosion (abortion is still the most common method of birth control).

7. Involve the imposition of a religious principle on the entire community by governmental sanction.

However, after comparing the chances of the two forms of social change, we in Colorado felt it best to attempt the legislative process. After all, a defeat in the legislature does not foreclose an attempt to get a favorable judicial determination.

This reasoning was reinforced by a feeling many of us had that America and the world are in fact undergoing drastic changes in their attitudes toward reproduction. Unlike the attitudes prevailing when the old abortion laws were put on the books, when we needed more population to fill up an empty land, the world in 1969 is in serious danger of strangling itself with too much population. The policy reasons for making an unwilling mother bear an unwanted child are gone, and are replaced with a widespread feeling that unwanted children are community burdens. Machines, not muscle, produce our crops and fight our wars. Governments are waging war against unwanted population growth, and India has gone so far as to propose a law requiring compulsory sterilization for all couples who have three or more children. The world is undergoing a reproductive revolution which will be as important as the industrial revolution. The old biblical injunction of “be fruitful, multiply, and replenish the earth,” is changing to “be fruitful but multiply cautiously.”

Thus we can say generally that community opinion has changed. But it is hard to speak of any general community opinion, for in our large, complex so-

ciety, containing as it does varying mores and attitudes within itself, there is a wide spectrum ranging from enthusiastic support, through indifference, to unmitigated opposition. The degree of success thus depends on a series of interactions and adjustments among people with varying attitudes toward particular laws. In the case of abortion, as with birth

control, the prevailing attitude is toward liberalization of existing laws and mores. People are demanding control over their own reproductive activities and are going to either change the laws, as we did, or ignore the laws, as do the approximately one million women who each year seek illegal abortions. Abortion law reform is an idea whose time has come.

THE ART OF BEING A FAILURE AS A THERAPIST

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Too much emphasis has been placed upon how to be successful as a therapist and too little has been written about how to fail. Twelve steps for failing in psychotherapy are described within the proper ideological framework, and it is argued that any therapist can achieve this end with proper training.

What has been lacking in the field of therapy is a theory of failure. Many clinicians have merely assumed that any psychotherapist could fail if he wished. Recent studies of the outcome of therapy, however, indicate that spontaneous improvement of patients is far more extensive than was previously realized. There is a consistent finding that between fifty and seventy percent of patients on waiting list control groups not only do not wish treatment after the waiting list period but have really recovered from their emotional problems—despite the previous theories which did not consider this possible. Assuming that these findings hold up in further studies, a therapist who is incompetent and does no more than sit in silence and

scratch himself will have at least a fifty percent success rate with his patients. How then can a therapist be a failure?

The problem is not a hopeless one. We might merely accept the fact that a therapist will succeed with half his patients and do what we can to provide a theory which will help him fail consistently with the other half. However, we could also risk being more adventurous. Trends in the field suggest the problem can be approached in a deeper way by devising procedures for keeping those patients from improving who would ordinarily spontaneously do so. Obviously, merely doing nothing will not achieve this end. We must create a program with the proper ideological framework and provide systematic training over a period

of years if we expect a therapist to fail consistently.

An outline will be offered here of a series of steps to increase the chance of failure of any therapist. This presentation is not meant to be comprehensive, but it includes the major factors which experience in the field has shown to be essential and which can be put into practice even by therapists who are not specially talented.

1. The central pathway to failure is based upon a nucleus of ideas which, if used in combination, make success as a failure almost inevitable.

Step A: Insist that the problem which brings the patient into therapy is not important. Dismiss it as merely a "symp-tom" and shift the conversation elsewhere. In this way a therapist never learns to examine what is really distressing a patient.

Step B: Refuse to directly treat the presenting problem. Offer some rationale, such as the idea that symptoms have "roots," to avoid treating the problem the patient is paying his money to recover from. In this way the odds increase that the patient will not recover, and future generations of therapists can remain ignorant of the specific skills needed to get people over their problems.

Step C: Insist that if a presenting problem is relieved, something worse will develop. This myth makes it proper not to know what to do about symptoms and will even encourage patients to cooperate by developing a fear of recovery.

Given these three steps, it seems obvious that any psychotherapist will be incapacitated, whatever his natural talent. He will not take seriously the problem the patient brings, he will not try

to change that, and he will fear that successful relief of the problem is disastrous.

One might think that this nucleus of ideas alone would make any therapist a failure, but the wiser heads in the field have recognized that other steps are necessary.

2. It is particularly important to confuse diagnosis and therapy. A therapist can sound expert and be scientific without ever risking a success with treatment if he uses a diagnostic language which makes it impossible for him to think of therapeutic operations. For example, one can say that a patient is passive-aggressive, or that he has deep-seated dependency needs, or that he has a weak ego, or that he is impulse-ridden. No therapeutic interventions can be formulated with this kind of language. For more examples of how to phrase a diagnosis so that a therapist is incapacitated, the reader is referred to *The American Psychiatric Association Diagnostic Manual*.

3. Put the emphasis upon a single method of treatment no matter how diverse the problems which enter the office. Patients who won't behave properly according to the method should be defined as untreatable and abandoned. Once a single method has proven consistently ineffective, it should never be given up. Those people who attempt variations must be sharply condemned as improperly trained and ignorant of the true nature of the human personality and its disorders. If necessary, a person who attempts variations can be called a latent layman.

4. Have no theory, or an ambiguous and untestable one, of what a therapist should do to bring about therapeutic change. However, make it clear that it

is untherapeutic to give a patient directives for changing—he might follow them and change. Just imply that change happens spontaneously when therapists and patients behave according to the proper forms. As part of the general confusion that is necessary, it is helpful to define therapy as a procedure for finding out what is wrong with a person and how he got that way. With that emphasis, ideas about what to do to bring about change will not develop in an unpredictable manner. One should also insist that change be defined as a shift of something in the interior of a patient so that it remains outside the range of observation and is uninvestigable. With the focus upon the “underlying disorder” (which should be sharply distinguished from the “overlying disorder”), questions about the unsavory aspects of the relationship between therapist and patient need not arise, nor is it necessary to include unimportant people, such as the patient’s intimates, in the question of change.

Should student therapists who are not yet properly trained insist upon some instruction about how to cause change, and if a frown about their unresolved problems does not quiet them, it might be necessary to offer some sort of ambiguous and general idea which is untestable. One can say, for example, that the therapeutic job is to bring the unconscious into consciousness. In this way the therapy task is defined as transforming a hypothetical entity into another hypothetical entity and so there is no possibility that precision in therapeutic technique might develop. Part of this approach requires helping the patient “see” things about himself, particularly in relation to past traumas, and this involves no risk of change. The

fundamental rule is to emphasize “insight” and “affect expression” to student therapists as causes of change so they can feel something is happening in the session without hazarding success. If some of the advanced students insist on more high-class technical knowledge about therapy, a cloudy discussion of “working through the transference” is useful. This not only provides young therapists with an intellectual catharsis but it gives them a chance to make transference interpretations and so have something to do.

5. Insist that only years of therapy will really change a patient.

This step brings us to more specific things to do about those patients who might spontaneously recover without treatment. If they can be persuaded that they have not really recovered but have merely fled into health, it is possible to help them back to ill health by holding them in long-term treatment. (One can always claim that only long-term treatment can really cure a patient so that he will never ever have a problem the remainder of his life). Fortunately the field of therapy has no theory of overdosage, and so a skillful therapist can keep a patient from improving for as long as ten years without protest from his colleagues, no matter how jealous. Those therapists who try for twenty years should be congratulated on their courage but thought of as foolhardy unless they live in New York.

6. As a further step to restrain patients who might spontaneously improve, it is important to offer warnings about the fragile nature of people and insist they might suffer psychotic breaks or turn to drink if they improve. When “underlying pathology” becomes the most common term in every clinic and

consulting room, everyone will avoid taking action to help patients recover and patients will even restrain themselves if they begin to make it on their own. Long-term treatment can then crystallize them into therapeutic failures. If patients seem to improve even in long-term therapy, they can be distracted by being put into group therapy.

7. As a further step to restrain patients who might spontaneously improve, the therapist should focus upon the patient's past.

8. As yet another step with that aim, the therapist should interpret what is most unsavory about the patient to arouse his guilt so that he will remain in treatment to resolve the guilt.

9. Perhaps the most important rule is to ignore the real world that patients live in and publicize the vital importance of their infancy, inner dynamics, and fantasy life. This will effectively prevent either therapists or patients from attempting to make changes in their families, friends, schools, neighborhoods, or treatment milieus. Naturally they cannot recover if their situation does not change, and so one guarantees failure while being paid to listen to interesting fantasies. Talking about dreams is a good way to pass the time, and so is experimenting with responses to different kinds of pills.

10. Avoid the poor because they will insist upon results and cannot be distracted with insightful conversations. Also avoid the schizophrenic unless he is well drugged and securely locked up in a psychiatric penitentiary. If a therapist deals with a schizophrenic at the interface of family and society, both therapist and patient risk recovery.

11. A continuing refusal to define the goals of therapy is essential. If a

therapist sets goals, someone is likely to raise a question whether they have been achieved. At that point the idea of evaluating results arises in its most virulent form. If it becomes necessary to define a goal, the phrasing should be unclear, ambiguous, and so esoteric that anyone who thinks about determining if the goal has been achieved will lose heart and turn to a less confused field of endeavor, like existentialism.

12. Finally, it cannot be emphasized enough that it is absolutely necessary to avoid evaluating the results of therapy. If outcome is examined, there is a natural tendency for people not fully trained to discard approaches which are not effective and to elaborate those which are. Only by keeping results a mystery and avoiding any systematic followup of patients can one ensure that therapeutic technique will not improve and the writings of the past will not be questioned. To be human is to err, and inevitably a few deviant individuals in the profession will attempt evaluation studies. They should be promptly condemned and their character questioned. Such people should be called superficial in their understanding of what therapy really is, oversimple in their emphasis upon symptoms rather than depth personality problems, and artificial in their approach to human life. Routinely they should be eliminated from respectable institutions and cut off from research funds. As a last resort they can be put in psychoanalytic treatment or shot.

This program of twelve steps to failure—sometimes called the daily dozen of the clinical field—is obviously not beyond the skill of the average well-trained psychotherapist. Nor would putting this program more fully into action

require any major changes in the clinical ideology or practice taught in our better universities. The program would be helped if there was a positive term to describe it, and the word "dynamic" is recommended because it has a swinging sound which should appeal to the younger generation. The program could be called the therapy which expresses the basic principles of dynamic psychiatry, dynamic psychology, and dynamic

social work. On the wall of every institute training therapists, there can be a motto known as *The Five B's Which Guarantee Dynamic Failure*:

Be Passive

Be Inactive

Be Reflective

Be Silent

Beware

REVIEWS OF THE LITERATURE

BEHAVIORAL SCIENCE FRONTIERS IN EDUCATION

Eli M. Bower and William G. Hollister, Eds.

New York: John Wiley & Sons. 1967. 539 pp. \$8.95

Behavioral Science Frontiers in Education is first of all a collection of some 22 separate chapters by more than a score of authors. The application to the school of theory, research, and ideas concerned with the strengthening of ego processes is common to all the chapters, and this, plus the fact that many of the writers are part of an established school of thought in educational circles associated with the late Kurt Lewin, provides to some extent a thread knitting the work together.

The authors are a distinguished group and most of them, partly with the encouragement of NIMH, have long been concerned with the general problem of exporting mental health orientations and clinical psychological concepts into the classroom teacher's life space. The reader often feels he has been here before with Ronald Lippitt, John Glidewell, and Richard Suchman, not to mention Florence R. Kluckholm, Hilda Taba, and Herbert Thelen.

Somehow as you read this volume you also feel that the schools, like the Hong Kong flu germs, have learned to handle these injections before they become operational. The old dilemma repeatedly emerges. A school is not a hospital, not even an outpatient clinic. Pupils are not patients; only by stretching an analogy are they usefully viewed as clients. The etiquette of gossip which governs teacher talk is definitely not privileged communica-

tion. What does come through is confusion concerning the relationship between the teacher and the mental health expert. At times it appears that the teacher is really the perceived client.

The language of the volume frequently denies any attempt of the clinicians involved to take command of the schools, and emphasis is placed on the cooperative nature of the venture to modify schools so as to strengthen the ego processes of pupils. The authenticity of the words ring less certain when the reader notes that the teacher's view is mediated by clinician-writers and only comes through the psychological jargon and value orientations of the mental health expert. Even less reassuring is the fact that while the authors carefully seek to avoid authoritarian control of the young and are careful of their needs, less care of the school teacher and administrator appears. The absence of teachers and administrators in the list of contributors to this volume, a volume intended to offer practical guidance for restructuring the school, footnotes the ambivalence.

Several chapters, however, indicate a growing awareness that the school is a social organization, different from the clinical type, even if not unique. Thelen's chapter with its emphasis on task and the classroom group as a work group takes a step in the direction of this awareness. Elton B. McNeil's chapter on the development of the school organization contributes more along this line. The chapter by John C. Glidewell and Lorene A. Stringer makes a significant contribution to this awareness. Even though the sociological field worker

might find their remarks limited, these two authors provide an insightful case study of their attempts to combine the work of institutions having similar human problems but different and sometimes conflicting ideological bases—the public school and the county health service. The resulting story of adjustment and partial cooptation of the health service personnel and the understanding of the school's need to wall off the "intruders" is a familiar one to students of school organizations. It is instructive, nonetheless, as it clarifies the fundamental and understandable misunderstandings between teacher and therapist.

Behavioral Science Frontiers in Education suffers from claiming too much. Title and publisher's jacket promise a greater breadth and newer set of ideas and concepts than find their way between these covers. What political science and economics have to offer for explaining the relationship of school and society as presently constituted and their possible futures is ignored. Omitted is the whole range of sociological concepts and research on the school organization, its constraints on behavior and possibilities for change. This would be unfair criticism were it not for the second overstatement of its authors—editors. Their claim is to selection of materials "on the basis of their ready applicability *in every school*" (italics mine); and further, "we have undertaken what we believe to be a difficult task, the translating of theory, research and intuitive hunches of the behavioral sciences into pragmatic procedures for teachers and school administrators." When that task is accomplished—if it ever will be—it is not likely to be done through a collection of chapters by twenty-odd writers. It can safely be concluded that neither the first part of the volume, presumed to be the more theoretical, nor the second which is supposed to "focus on the utilization and application of research" with feasibility as one of its key words, will send either teacher or administrator running out crying "Eureka."

The book is better however than the judgment which must be rendered if the "how to" the immediately practical is

taken seriously. For example, Lawrence S. Kubie's challenge of "any forward movement in education waits for education to develop its own corps of pathologists . . ." taken with Fred T. Wilhelms conclusion that "there is no set of competencies and practices which equals the difference between good and poor teaching" hardly yield possible applications for every school. But these chapters taken seriously would demand discussion reaching to the foundations of the public educational enterprise as we know it today.

It is to this important task, rather than to immediate and practical pink pills, that some of the chapters in this book can take the reader.

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SOCIAL CLASS, LANGUAGE AND EDUCATION

Denis Lawton

New York: Schocken Books. 1968. 180 pp. \$5.00

The impact of culture upon the forms and uses of language is a recurrent theme in Denis Lawton's book. This thin volume is a fine example of scholarly writing, an art with deep historical roots in England. It made me wonder whether a comparison of English and American books on education would not reveal a consistent superiority in style and conception among the former. Such a comparison may be a useful analogy to the evaluation of lower-class and middle-class language explored by the author.

Lawton's emphasis upon the pivotal role of language in education is shared by many psychologists, educators, and social scientists. Of particular importance in this regard is Basil Bernstein's theory of social class differences in language codes. Though the author is mildly critical of Bernstein, he describes Bernstein's theory in a clear and concise fashion. Lawton also succeeds in placing Bernstein's sociolinguistic theory into an intellectual context of great com-

plexity. Studies of childrearing practices are interlaced with a discussion of the Whorfian controversy of language and thought. Many other topics are introduced but they are all pertinent to the major themes of the book. "To ask whether language is a primary or secondary influence is less important than to think of reciprocal relations between language and culture, language and social structure, language and cognition."

Of central concern to Lawton is the issue of educability among low-income children: "There is little doubt that there exists a social-educational problem: a great deal of potential is wasted, or looking at the problem from a different point of view, the education of large number of working-class children is below a satisfactory standard. There is evidence to support the view that *inadequacy of linguistic range and control* is a very important factor in this underachievement, and that linguistic underachievement is a 'cumulative deficit,' i.e. it is a disadvantage which generates a vicious circle of difficulties increasing in magnitude as school progresses. . . ."

Though the comparison of linguistic skills among children of two differing social classes has empirical support, it is an oversimplified and somewhat fallacious emphasis in much contemporary research. Because of the serious limitations of contemporary education, differences in children's success in profiting from schooling has been traced to their home environment. Indeed, professionals, whose reliance upon words as conscious tools is highly developed, tend to stimulate verbal expression in their young children. In contrast, men and women engaged in a small business develop in their young children the habits of responsibility and hard work. The informal instruction of the home, then, reflects the skills and attitudes best known to the parents. Children of uprooted farmers and manual workers are less well-prepared for the particular type of instruction engaged in by teachers with specific skills and attitudes. But this hierarchical arrangement of academic achievement, dependent upon the skills of the home, has been dramatically modified in the past. Millions of children of illiterate peasants and immigrants have

become professional engineers, scientists, college professors, or office workers in one generation in this country as well as in the socialist countries. In periods of rapid social change, when there is a serious need for vast increases in brain power, societies have found ways for modifying the effects of class-linked opportunities for educational success (such as the G.I. Bill in this country or the people's colleges abroad).

But the current emphasis upon the limitations of the low-income home is a result of contemporary conditions in Great Britain and the United States (countries in which such theories are particularly popular at present). The youth are not presented with greatly expanding opportunities in these countries, and thus *selection criteria for limited opportunities are often confounded with criteria for educability.*

It is Lawton's intention to add specific details to the Plowden Committee's report on primary education in Great Britain. He supports their goal to increase social and educational mobility for working-class children. He suggests that "teachers should become more sensitive to the kind of analysis which would enable them to distinguish in the so-called middle-class culture what is of cognitive importance from what is irrelevant to the educational process. Far too often it seems that schools are emphasizing trivial aspects of middle-class life (such as etiquette and social conventions) and neglecting important cognitive areas." The full development of human intelligence is unquestionably a proper task for education. However, what is questionable about such a premise is that it can be modeled upon middle-class life. It would be similar to the argument that books in education should be modeled upon those published in England because they do excel in clarity and stylistic elegance. Scientifically, we have never had greater opportunities toward the development of the human mind, but socially, our views appear increasingly myopic.

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WOMEN AFTER TREATMENT

Shirley S. Angrist, Mark Lefton, Simon Dinitz, and Benjamin Pasamanick

New York: Appleton-Century-Crofts. 1968. 333 pp. \$7.00

The ambitious aims of community mental health programs are hampered by the lack of knowledge of many basic issues. How to assess the mental health of people in a given community? How do people who seek psychiatric help differ from those who do not? What are the effects of psychiatric treatment in the long run? What are the effects of the community upon the former patients? Only by knowing answers to these and similar questions, can psychiatry move to its main task of preventive care.

Solutions cannot be provided, however, without help of clinical psychology, social psychology, sociology, and other branches of behavioral sciences. The present book, in such an interdisciplinary spirit, seeks answers to some of these questions. A sample of 287 female patients was studied longitudinally and compared with a control sample of supposedly healthy/normal, non-treated female neighbors. The patients were diagnosed mainly as functional psychotics and psychoneurotics, but there were also some organic cases. Data were collected during the treatment period and in follow-up studies after six months, after two years, and at a seven-year rehospitalization check. Female neighbors of the patients, 157 altogether, formed a control group to be compared with a subsample of "community patients," i.e. patients who had been in the community after discharge for at least six months without return to a mental hospital. The sources of data collection were hospital diagnoses of patients, interview ratings, information given by patients, by controls, and by husbands or other "significant others" of patients and controls. The interview schedules were designed to collect information on such topics as domestic performance, social participation, and psychological functioning (description of symptoms of mental impairment). The collected information was condensed into measures that could be handled statistically.

As perhaps might be expected, the con-

trol group had fewer symptoms than the group of community patients even after treatment, and the control group was more competent in domestic duties—as judged by the significant others—and also in social activities. But the controls did have a surprisingly high number of symptoms; one-third of them were unable to shop and handle money. When patients and controls were matched on marital status and other characteristics, the two groups manifested similar profiles in the areas of instrumental role performance (domestic and social activities), role expectations, and tolerance of deviant behavior by the significant others. From the entire sample of patients, 32% were readmitted at least once within seven years, almost half of these during the first six months. Their performance was inferior compared with the performance of the "community patients" in psychological functioning; in other words, they exhibited more deviant behavior. But their overall performance—cleaning house, etc.—did not differ significantly from that of community patients. Among 12 different psychiatric variables, only one, diagnosis, related significantly to posthospital performance level. And of the several social variables, only marital status proved to be significantly and consistently associated with performance level: married women were superior to unmarried women.

These are only some of the results. Of great interest is the interpretation of findings. The authors conclude that their original sociological-environmental hypotheses, e.g., that the social world to which the ex-patient returns is far more instrumental in his fate than any illness or treatment variables, are not supported by the data. The social factors were not found to explain the distinction between patients and nonpatients and between the community patients and returnees. Still, the authors conclude, social characteristics like marital status, role expectations, and tolerance of deviance do influence role performance of both healthy and sick persons and are therefore partly predictive of posthospital performance.

On the basis of the results of their study, the authors challenge "the common assumption of role theories that performance

is primarily determined by expectations of significant others." They favor the accommodation hypothesis: the better the performance of housewives, the more the significant others expect of them. "The stance taken here," they say, "serves to bring new skepticism into old assumptions about behavior as effect rather than cause."

In their introduction the authors discuss the recent history of hospital development and review the relevant research literature. The reviewer would disagree with two of the side issues they raise. First, it may be doubted whether schizophrenia occurs at a persistently lower rate in women than in men. The rate for first admissions in Czechoslovakia, for example, are lower for men for all mental disorders except alcoholism and drug addiction. Secondly, the authors state that the aim of therapeutic communities is "to create a . . . conflict-free . . . setting with minimum stress." This aim would hardly be acceptable to all therapists, many of whom purposely design environments where patients can reexperience conflicts under more favorable conditions than they experienced them earlier in life.

It is to be hoped that the study will be continued, perhaps on larger and more psychiatrically homogeneous samples such as selected groups of schizophrenics. For the benefit of future researchers, and all other readers, I would also hope that a dictionary of terms giving their generally accepted definitions could be developed. It would make reading easier and might counteract the too natural tendency of us all to stretch meanings of concepts beyond their defined (operational) meanings and so interpret the findings too generally. The reader would be able to look into such a dictionary for the meaning of "domestic performance" and find that it is nothing more than a rating made by a significant other and not a professional rating made, for example, by a social worker. He would be able to look for the meaning of terms like "social experience" in statements like: "This study was based on the sociological assumptions that patient experiences are primarily social experiences." He could find what the authors meant by "illness"

and "instrumental behavior" in statements like: "It is essential that the analytic distinction between illness behavior and instrumental behavior be kept apart" and "that the issues related to illness not be confused with those related to inadequate instrumental role performance."

The great value of this elaborate and careful study lies in its design: neighbors as controls; the possibility of comparing the assessments of patients with those of the significant others; repeated followup studies for more than seven years. The results and the authors' analysis are challenging, not only for psychiatrists but also for role theorists and other behavior scientists.

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RECENT ADVANCES IN BIOLOGICAL PSYCHIATRY, Vol. X

Proceedings of the 22nd Annual Convention and Scientific Program of the Society of Biological Psychiatry, 1967

Joseph Wortis, Ed.

New York: Plenum Press. 1968. 328 pp. \$19.50

It should be mentioned first of all that the content of this book is much broader than its title, and many articles are only indirectly related to recent advances in biological psychiatry. Problems of neuropharmacology, investigations related to memory, neurochemistry, and reflex-conditioned behavior are all discussed. Their inclusion may be understood in view of the fact that at the present time it is difficult to say where crucial aid in the development of biological psychiatry will come from, at least as the editors of this book perceive it.

This review, however, will deal only with those problems which in our understanding comprise "recent advances in biological psychiatry." Most such problems are in

Part II of the volume, "Psychopharmacology," which contains four articles related to the investigation of certain combinations possessing psychopharmacological effects that are psychomnemic* as well as therapeutic.

In the first of the four articles H. Tanimukai, R. Ginther, Y. Spaide, Y. R. Bueno, and H. E. Himwick report how bufotenin and certain others N,N-demethyl derivative indoleamines possessing psychomnemic effects were investigated, with the help of refined analytical methods (paper chromatography, stratified and liquid-gas chromatography), in the urine of ill schizophrenics in the controlled and experimental period. In the experiment, conducted with a very small sample (four patients) but in very well-controlled conditions, the presence of bufotenin was demonstrated in the experimental period in the urine of the patients after development of psychotic symptoms. The obtained results are viewed as one more support for the hypothesis of the role of disturbance of oxidation of indoleamines in the process of pathogenesis. It should be pointed out that the study reported here is the interesting and logical extension of the whole series of research investigations systematically conducted in that direction by H. Himwick and his collaborators.

F. W. Grant, the author of the second article in this section, beginning with the discussion of pharmacological role of changing processes O- and N-oxidation decided to investigate the influence of certain factors originally of an emotional nature upon process of deoxidation. Considering models for such investigation, he selected what he calls "index of oxidation"—relationship between products of the exchange of aminosine differentiated one from another by the degree of deoxidation. In the investigation conducted on the group of 20 patients with various diagnoses, Grant shows that emotional stress has essential influence upon the index of oxidation. But the character of the obtained

results do not permit a final conclusion in reference to this problem. In his short article the author regrettably does not explain why in the process of selection of a model he selected chlorpromazine, which on its own actively influences emotional condition.

In the article by A. G. Bolt and I. S. Forrest, the emphasis is upon mechanism of hyperpigmentation, a condition which occurs comparatively infrequently (about 1%), as a complication related to prolonged treatment with chlorpromazine. The authors demonstrate that at the root of this mechanism is the relationship between one of the metabolites of chlorpromazine/7 hydro-oxychlorpromazine/and certain protein. Such reaction takes place as the result of a genetical predisposition.

The last article of Part II is devoted to the investigation of MAO inhibitors. The essential element of this research was its use of purified samples of ferment, which enabled the authors to obtain very interesting data. In part, they were able to obtain very good correlation between MAO-inhibitory activity and antidepressants and the degree of their clinical effect. In contrast to generally accepted modern belief, the authors were able to show that antidepressant imipramine, in well-sterilized MAO samples, also has an inhibitory effect. On the basis of comparison of inhibitory qualities of certain antidepressants and complex reactions (arrangements), the writers suggest the hypothesis relative to mechanism of inhibitory activity of these elements based upon characteristics of sugar process in fermentation.

In another section of the volume, a paper titled "Molecular Pharmacology of Hallucinogens" reports the work of Jonston and Bradley. Using primarily the method of lever processing avoidance conditioning developed by Bovet and Gotti, the authors reveal again the high differentiating sensitivity of conditioned-reflex reaction in relationship to various psychopharmacological conditions and potentials of that reaction for the goals of the molecular psychopharmacology. The basic methodological value of their work is in the fact that they used a wide range of mescaline

* This word appears to be a neologism, meaning "reminiscent of psychosis"—ED.

derivatives. They demonstrate that three representatives of various groups of hallucinogens—LSD, mescaline, and N,N-dimethyltriptamine—did not influence conditioned-reflex reactions with the introduction of chlorpromazine. Furthermore, they show that oxidation of the ring of mescaline leads to heightening of its activity. Activity of a molecule specifically increases with oxidation of 3, 4, and 5 location. It is especially pleasing that this data has clinical analogy. At the same time, however, this research demonstrated disappearance or lessening of activity of certain acid and alcoholic derivatives of mescaline. On the basis of these findings, the authors arrive very logically at a conclusion about the metabolic changes caused by mescaline which explains its psychomnemic effect and the physiochemical basis of that effect. One may agree with their conclusion that oxidation of mescaline is a distinct analogy of possible deviations in the process of oxidation of noradrenaline which can lead to formation of a substance similar to mescaline.

In Part IV of the volume, two articles are worth mentioning—the two dealing with the problem of influence of shock therapy upon the memory of patients. The first, a contribution by L. F. Small and J. A. Small, has phenomenological character and is designed to reveal variations in the type of amnesias in EST and in indoclon therapy. The authors did not find differences in the effectiveness of these types of therapy, although they did demonstrate that amnesias following indoclon therapy are found less frequently but have a tendency to last longer.

The second contribution, by W. W. Zuna, J. Rogers, and A. Krugnian, is devoted to the analysis of adequate methodology for the investigation of memory in depressive reactions. The authors emphasize the Bender Visual-Motor Gestalt Test, the Benton Revised Visual-Retention Test, the Wechsler (memory) Scale, and the Illinois Test of Psycholinguistics, considering the last one as being the most sensitive. The Illinois test, in addition, permitted the authors to extract a factor of long-term

memory from within various mechanisms of memory.

Almost the only method of direct investigation of the brain of schizophrenics is electroencephalography. Of particular interest in this book, therefore, are two articles prepared by this method and published under the overall heading of "EEG and Neurophysiology." In the article "Some Electrophysiological Differences Between Chronic Schizophrenic Patients and Normal Subjects," Rodin and collaborators have proven new objective EEG characteristics for schizophrenic patients and normals. It is worthwhile to pay attention to the data they obtained relative to lowering of synchronized activity of brain hemispheres in schizophrenic patients, and the correlation of amplitude of the evoked potentials with certain clinical characteristics of the patients. Also it should be mentioned that the correlational method, widely used by the authors of this investigation, has to be very exact; it is doubtful whether presence of correlation between alpha activity and simple proprioceptive investigation is sufficient for the conclusion of propiocentral bases for alpha activity.

The work of C. H. Shagas is an example of a careful methodological treatment of the topic. He has already been concerned for many years with investigation of evoke-potentials in psychiatric patients. In earlier work he had shown the differentiation between normals and patients in terms of evoke-potential. However, in those earlier investigations several important factors were not considered, namely the importance of height and sex for the evaluation of evoke-potential. Here he reports that it became evident that knowledge of these factors enables one to differentiate not only groups of patients and normals but also various groups of psychiatric patients, schizophrenic patients, depressive psychotics, and dysthymic psychoneurotics—thus apparently proving differences in biological bases of these illnesses.

In general, the papers published in *Recent Advances in Biological Psychiatry* are of significant theoretical interest, reflect various aspects of contemporary psychopharmacology, and will be read with in-

terest by physicians and investigators of various specialties.

G. I. Aurukskii, M.D.

A. V. Nemtsov

S. H. Zaytzev

Moscow Institute of Psychiatry

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translated by

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PSYCHIATRY IN THE COMMUNIST WORLD

Ari Klev, Ed.

New York: Science House. 1968. 276 pp. \$10.00

This collection of descriptive reports on psychiatric theory and practice in the Communist world provides a unique opportunity for becoming acquainted with psychiatric developments in countries where the culture, values, and system of government were considered after the end of World War II to be opposed to the American way of life. Despite the recognition now that Communist countries are not all exactly alike, the differences between them as a group and the U.S. continue to be regarded today as basically contradictory, if not conflicting, in character. The most provocative and in the opinion of this reviewer valuable contribution of this book is its reflection of the almost paradoxical contrast in these countries' approach to mental illness as compared to that of the United States.

As is often the case in edited collections, this work is uneven in the quality of the reports presented. While one may entertain the notion that these reports vary in their degree of candor and accuracy, a condition not unheard of in similar American publications, none of the reports is striking in its scientific character. Little is offered in the way of epidemiological studies or systematic evaluation of the effectiveness of any of the practices described.

Despite these deficiencies, however, the reader will be rewarded by exposure to a psychiatry responsible for the mental health

needs of a large part of the world's population. In addition, the reader will almost certainly gain a more thoughtful, if not different, perspective with which to view American psychiatry.

The psychiatries in each of the nine countries reviewed are not identical in theory and practice. Still, there are compelling similarities that are particularly impressive when compared to contemporary American psychiatry. The most prominent and unifying common theme is their public health approach. While the use of outpatient clinics and hospitals is not ignored, front-line prevention and rehabilitation programs carried out in less traditional settings are given equal if not higher priority. The intensive, long-term, clinically isolated one-to-one treatment model, so prevalent in American psychiatry, is not a major focus. While it is not demonstrated in these reports, almost all the nine countries accept the importance of epidemiological studies and their necessity both for establishing outcome indices and for evaluating program effectiveness.

Considerable emphasis is placed upon continuity of care, with the community linkage serving as the major focus. The wide use of nontraditional professionals and various kinds of professional and paraprofessional staff is described in all the reports. Whether or not actual practice concurs with the written word (the latter, often a better index of expectations than fulfillment), the public health model is clearly the basic ideal.

Certainly, all of these descriptions present a greater synthesis of health, education, and welfare services than can be claimed for any community in America. Perhaps this has been more possible in these countries because of their different political structure. Such an effective synthesis is clearly desirable in the U.S., however, and presumably could be achieved in this country without sacrificing our democratic system, given the same commitment to public health service.

The most common and influential theory of behavior utilized in all these Communist countries is that of Pavlov. But despite the attention to Pavlovian theory, the clinical

practices described in these reports would support the rose-by-any-other-name hypothesis. With the exception of such idiosyncratic and culturally unique methods as acupuncture, almost all the psychotherapies described are basically nondeterministic in approach and have functional treatment goals. The primary aim of all of them is to improve the patient's behavior. While increased understanding and greater insight are considered important in contributing to this aim, they are not regarded as sufficient goals unto themselves.

A thread which runs consistently throughout the therapies described is the right of the patient to negotiate his treatment outcome with the therapist. This implies some patient autonomy in the treatment transaction. Even though I am not convinced that such patient autonomy and sharing of decision-making is sought or achieved in all cases, it is nevertheless surprising. One would not expect this to be true in countries where the individual rights and freedoms of citizens have been widely described as seriously restricted. Even in the discussion of psychotherapy practices in Communist China there is considerable emphasis placed on the patient's active role in treatment. The patient is described as having an important responsibility for treatment, outcome, and his need to be active and not passive in the treatment interchange.

The absence of any systematic effort to present a report of more rigorous scientific caliber is one of the disappointments of this collection. Some of my other disappointments have to do with the lack of explicit discussion of training procedures for professionals and nonprofessionals. More importantly, only the barest outline is given of the nonprofessional's functions. Those sections concerned with training deal with the training of the professional almost exclusively. I was also surprised as well as disappointed at the lack of any adequate presentation of the use of sleep therapy, particularly in the Soviet Union.

These disappointments aside, this book is recommended as worthwhile reading. The prominence of the nondeterministic approach to human behavior found in these reports is important in considering the psy-

chiatric practices and mental health programs in these countries. Certainly, this is a more optimistic and hopeful approach to helping people solve their life difficulties than one which fixes the patient in some predetermined genetic, psychogenetic, or environmental manner.

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CURANDERISMO

Mexican-American Folk Psychiatry

Ari Kiev

New York: Free Press. 1968. 207 pp. \$6.95

In this book about Mexican-American curanderos (folk healers) in Texas, Ari Kiev continues to study and compare primitive psychiatry with modern psychotherapy. The conclusion he reaches is that the curandero, basing treatment on a combination of native insight, knowledge of his own culture, religious ideology, and traditional medical techniques, often produces therapeutic results. In contrast, "there is no evidence that dynamic psychotherapy is of more value than such forms of treatment as curanderismo."

Dr. Kiev does not provide more than anecdotal evidence that curanderismo is of more value than dynamic psychotherapy but does explain why many Mexican-Americans prefer the healer to the psychiatrist. In part, the choice reflects a decision to reject the values of the dominant Anglo culture which treats the Mexican-American as inferior and reassert commitment to an ideal of a simpler peasant culture. Many Mexican-Americans experience the Anglo culture and its psychiatry as cold and detached, whereas the curandero treats the patient with a paternalistic or maternalistic respect for his right to avoid painful conflicts. The patient is allowed to feel that he has been overcome by forces beyond his control, rather than having to accept responsibility for himself or to decide between conflicting wishes. He is encouraged to be submissive, to be pas-

sive, and to gain strength from accepting traditional beliefs. The curandero does not expect him to "grow up" and be more "realistic."

Dr. Kiev's underlying argument is that both North American psychiatry and Mexican curanderismo attempt to adjust the patient to his culture, and he suggests that the goals of contemporary dynamic psychiatry have developed "more for their compatibility with the ethos and value system of our own culture than for any well-founded scientific reason." This seems to imply that curanderismo and psychotherapies that adjust people to society both have equal functions within their respective cultures, but it does not tell us how well either work, how the patients benefit. We do not know the costs to the patient of adjusting, either to a modern industrial society or to a simpler peasant society. In Mexico, the curandero succeeds at times in alleviating symptoms, as long as the patient wants to submit himself to traditional practices, but he also fails to help villagers whose originality and sensitivity may be stifled by the demands of peasant society. The peasant who experiences a conflict between regressive impulses and strivings for independence is not likely to find anyone who will help him to understand his dilemma and its meaning for him. The curandero, like the psychiatrist, may alleviate anxiety at the cost of the individual's sense of potency and joy of life. One wonders how many illnesses, not usually diagnosed as psychosomatic, are in part the leftovers of psychiatry or curanderismo that "adjusted" the patient.

Another central thesis of *Curanderismo* is that understanding the kinds of conflicts people are likely to experience requires knowledge of their culture and the dynamic character traits rooted in it. It is on this point, which is a good one, that the book is weakest, when it attempts to explain the character of the Mexican-American in terms of a rural-agrarian, Mexican village background. Sometimes Dr. Kiev too readily accepts stereotypes for reality, such as the idea that *machismo*, the cult of male aggressiveness, touchy pride, and fantastic sexual prowess, describes the type of man most admired by Mexicans. In fact, many

Mexicans distinguish between exaggerated masculinity on the one hand and a different concept of manliness on the other. In an intensive study of a Mexican village, we have found that most of the people consider the macho type of individual a braggart and a bully, a man who is trying to hide his inner weakness and fear of women.* In contrast, the kind of man most admired by villagers is reserved, formal, hardworking, and trustworthy. Considering the North American attraction to James Bond-type heroes and Western gunslingers, a good case could be made that we admire *machismo* more than do the Mexicans.

It is also possible that many Mexican-Americans have a nostalgic, romanticized view of Mexico. According to Dr. Kiev they feel that the male is more macho in rural Mexico, but that in the United States he has been semicastrated by Anglo culture so that he no longer dominates his women who, influenced by Anglo ideas, are supposedly becoming less docile. Although the Mexican-American's losing battle with a white, racist Anglo society leaves him feeling defeated, it is a mistake to think that in Mexico today the women are submissive and the old traditional values are unchallenged. Even the peasant in Mexico today is pressured by an increasingly profit-oriented, industrializing society where the measure of a man's worth is his earning power. In the new developing society, relations between the sexes are changing. Not only in Texas but also in Mexico City and smaller towns, Mexican women now earn money and absorb ideas about feminine rights. The new freedom and changing aspirations of the women add strains to the relationship, or more accurately the war, between the sexes. Although Mexican peasant society consciously proclaims the ideals of a strong patriarchy, in fact there has been a strong underlying challenge to male dominance by the women, at least since the Spanish conquest when the Aztec patriarchy was crushed. One result is that while strong and determined men live according to the patriarchal ideals, a num-

* See Erich Fromm and Michael Maccoby, *Social Character in a Mexican Village*, Prentice-Hall.

ber of the more passive-receptive men are defeated by the women. They are the ones who try to compensate for their defeat by *machismo* and alcoholism.

Curanderismo is most valuable in describing the traditional Mexican classification of illnesses, their causes and treatment, and in calling attention to the way in which psychotherapies reflect cultural patterns. Dr. Kiev also tries to grasp the Mexican character, but in fact there is a range of Mexican character types which must be understood in terms of socioeconomic and cultural-historical determinants.

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UP FROM POVERTY

New Career Ladders for Nonprofessionals

Frank Riessman and Hermine I. Popper, Eds.

New York: Harper & Row. 1968. 332 pp. \$7.95

This collection of 23 selections by leading specialists in the field explores both the practice and potentials of new careers for the poor and the nonprofessional. The new careers movement is characterized by three major long-range goals: providing the disadvantaged with useful work, including opportunities for personal growth and educational advancement; developing new sources of manpower for the vastly undermanned human service fields; and reorganizing human service agencies to meet more efficiently the needs of their clients. These goals are examined from the standpoint of theory and practice: what they mean, how they have worked, and what we can hope for in the future.

The late Senator Robert F. Kennedy in a paper entitled "Government, Jobs and New Careers" points out that "in the health services, the national league of nursing estimates a deficit of 344,000 registered nurses by 1970. For the same year, mental health services predict a deficit of 200,000 employees for state and county hospitals." A major failure of the new careers program, states George Brager in his paper

"The Indigenous Social Work Technician Mobilization for Youth," "has been the inability of the nonprofessional to facilitate communication between the low-income resident, conventional persons, and institutions. Language difficulty, lack of polish, and working-class status in addition to inadequate education have resulted in many minority persons being frequently dismissed by the personnel of large service systems."

The key to successful job and academic experiences must be the quality of the training they receive. Supervisory staffs of the employing agencies need themselves to be trained both to plan for new careers models and to devise a training curriculum for their new manpower. *Up from Poverty* discusses the following elements as those that must be included in a new careers curriculum:

1. What tasks the nonprofessional will be required to perform at the initial entry on the job and what tasks he will be required to perform after three months, etc.
2. The core curriculum consisting of communication skills, group methods, etc.
3. The nonprofessional needs considerable knowledge about the system in which he will be operating, the relevant roles and their definition, customs, and norms.
4. Basic education starting with literacy and moving toward high school equivalency.
5. College and career-oriented education.
6. The development of creativity and learning power.
7. Supportive services.
8. Attitudes needed by an aide, including work habits, grooming, job-getting skills, relation to supervision, and confidentiality.

This publication should prove invaluable as a handbook for specialists in the field and for teachers, counselors, and the general public. The new careers program has begun to have a tremendous impact for the disadvantaged, but let us hope that adequate support and financing for its continued development will be forthcoming.

Claude M. Ury, Ph.D.
Educational Consultant
Kensington, Calif.

LETTERS TO THE EDITOR

(continued from page 546)

the original survey and that 61 percent of the matched children, those who had received no psychotherapy, were also much better. The experts who had rated the original case histories on a five-point scale ruled that 55 of the 87 children (63 percent) had shown definite improvement."

Let me now emphasize the fallacy of these conclusions. It is naive to assume that child psychiatry is still in the bonds of a stereotyped dialogue between the psychiatrist and child. Today our help includes discussions with a child, with the parents (separately or together), the schools, the family physician, and the clergy. In fact, a modern child psychiatrist is the coordinator of all environmental factors that are influencing the child, and his help is not limited to the child's well-being but should improve the family balance as well. Does a patient with pneumonia deserve help even though the condition may improve spontaneously? Does an injured finger which will heal by itself not deserve a dressing? In short, isn't the suffering, the anxiety of a family and a child worthy of attention?

The help that comes from a consultation with a professional person who can clarify issues and help families live with such problems in greater comfort is enough of a justification for such assistance.

To soothe a painful process is a noble deed.

*Leon Tec, M.D.
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More "Help" for the Poor

TO THE EDITOR:

The very timely article "Clinical Cooling Out of Poor People" in the April 1968 JOURNAL was helpful but incomplete. The real expert in this procedure goes beyond the suggestion of the authors into a more complete kind of "cooling out." The job is to do more than simply persuade poor

people that they don't need the service or to leave them with the "feeling that they alone have undone themselves." Valuable as this may be, there are greater goals than simply getting poor people off of our waiting lists!

The full mission is to *first* persuade them that they are, in fact, mentally ill. When this is done, then they can be "helped" to see that they are currently untreatable via the recommendations in that article. If this first step is accomplished with some skill, they will quit thinking about their rotten housing, the future of their kids, and their dehumanizing jobs (or unemployment) and start believing that they are in this mess because they have a mental disease. Their energy will then be directed to learning how to be "acceptably sick" so as to become treatable at some future time.

The importance of this first step (teaching poor people to see themselves as mentally ill) can't be understated. If this isn't adequately done, the superficially "cooled out" poor person might just look for another approach and wind up getting involved with some inner-city community action group and start expecting better housing, better jobs, and better schools.

Some hope can be found in the growing infusion of comprehensive community mental health centers in the inner city. While they might be too late to "cool out" angry poor black people, they might at least prevent poor white people from finding out that they don't deserve what they get in this society.

There is reason to be reluctant about getting too hopeful, though, because sometimes it seems that some mental health clinicians aren't faithful to their mission and wind up admitting that some of the problems poor people have are real problems; one even hears of some who take advocate roles. Maybe another year of professional education should be required for the members of the various helping professions to seem interested in working with poor people.

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Reply to Bruno Bettelheim

TO THE EDITOR:

I believe that Dr. Bettelheim's reply to my review of his *The Empty Fortress* (October 1968 JOURNAL) has corrected a somewhat unfair picture. Let me mention what I take to be the most important shortcomings in the review as well as some of the original shortcomings of the book which are underscored by the author's reply.

First, as to the involvement and participation of Bettelheim's co-workers: I recently read the articles mentioned by him in reference to my suggestion that his skills are somewhat "inimitable." My view now seems exaggerated. Many persons undoubtedly took part in the care of the children and it is altogether unfair to place sole responsibility for the conduct of the programs, their success and failure, onto Dr. Bettelheim. Surely, the integrity of the effort as a whole rests largely upon having a sympathetic, trained, and stable group of co-workers. Further, collaboration was perhaps involved in the writing of what is surely the preeminent book on infantile autism now available. Let the reader be clear: nothing yet published on the origins and maintenance of autism can satisfactorily be compared to Dr. Bettelheim's book. There are, however, shortcomings in it and they need to be pointed out. Such a review of the book in this JOURNAL was a most appropriate context.

The most serious statements in Dr. Bettelheim's reply revolve around the allegations (1) that I do tort to the facts as published, (2) that by the concentrating on only four pages of the followup data I perhaps deliberately misguide the readers' impressions of the book, (3) that I lie about the relative severity of cases handled by the author in contrast to children treated by Dr. Lovaas, and most gravely (4) that the implication of my critique is a fascistic, Stalinist, and pro-Saigon totalitarianism.

First, the claim is made that I misread the data. Presumably this means that my hypothetical table (TABLE 3, page 929) is incorrect. Despite the opportunity to set aright that presentation and the claim that

it is wrong, Dr. Bettelheim does not in fact do so. Read closely, one sees that one case does appear in the "good" category of initially nonspeaking children. This was precisely the case mentioned in the book on page 9. He says that "some of the nonspeaking children fall in the 'good' category, hence it is erroneous to put them all in the 'fair' category." How many? He continues: "six of the eight nonspeaking children acquired speech, even though four of them were rated failures because their social adjustment on leaving was not considered fair." The book reports 14 nonspeaking children. Perhaps this information refers to the eight children whom he reports as showing "meaningful improvement" (the 57% appearing in my TABLE 2, see page 928 of the review or 414 of the book). If this is the case, then (because the marginals of the table are fixed by his original report) TABLE 4 should show 20, 4, 6, and 10 instead of the suggested 22, 2, 4, 12. The consequence is simply that the initial speech skills of the child are somewhat less predictive of eventual outcome than was earlier suggested. On the other hand we still cannot be certain about these figures since requisite information is lacking.

In trying to clarify the question of what constitutes "adequate social adjustment" for these children, Dr. Bettelheim again asserts that my assumptions are "contrary to fact" while, in fact, these assumptions were literal interpretations of clear English prose: "The fifteen classified as 'fair' results are no longer autistic, though eight of them should now be classified as borderline or schizoid, since they have made only a fair social adjustment. The remaining seven do much better and suffer only from more or less severe personality disorders, which limitation has not kept them from making an adequate social adjustment" (page 415 of the book). Of course, we may misunderstand what is meant here by "adequate." We need not question that; it may be taken at face value as given by the author and I cannot see how anything has been "misread." Serious questions nonetheless rest on the matter of definition since that is the specific means whereby comparisons between different programs may

be evaluated by those of us who, though persuaded by "inner logic," are cautious nonetheless.

Secondly, while I do not claim any special skills in evaluating individual case histories I am quite competent in evaluating across-case generalizations. The latter problems are far more important than Dr. Bettelheim is willing to concede, and this is why he feels it is grossly unfair for me to concentrate on "some four pages." It is altogether fair to question the procedure of exclusive reliance upon individual case histories, especially so when the data is presented in a purely narrative form uncontaminated by small compromises to contemporary social science analysis. This in spite of the fact that Dr. Bettelheim is closer to extensive data on autism and treatment effects than anyone else of whom I know. The problem concerns the generalizations that may be made of observations that are relevant to a science of human behavior. That is, theory. The problem is analogous where therapy is the chief concern. I did not wish to make so obvious a point explicit. That the importance of clear and unambiguous across-case information escapes the author cannot be made the responsibility of the reviewer.

Put another way, we are more interested in learning what may be done for autistic children than in learning what was done for Laurie. Clearly there is no necessary conflict and this is not to denigrate a case history approach. The latter serves at its best to preserve details that may have importance to readers and practitioners that are perhaps not evident even to the writer. As to the relative possibilities of bias or downright dishonesty, the readers of the book are no more at the mercy of the writer for accuracy in tabular analysis than they are in evaluating a case history. Both are important and probably equally so. And honesty must always be assumed in the absence of contrary evidence.

Thirdly, Dr. Bettelheim suggests that "not a shred of evidence" exists to support the statement that Dr. Lovaas works with children who are more disturbed than those reported in the book: "the case of Laurie alone gives the lie to this state-

ment." In the book we learn one of the conditions for Laurie's admittance to the Orthogenic School: "we could not consider Laurie for enrollment if shock treatment was given, and our conditions were observed." In the review itself a quote showed that one child was withdrawn because it was learned that she had been subjected to electro-shock treatments a year before she arrived, "which precluded effectiveness in our treatment methods". Now I certainly don't think shock treatments of any sort have even the barest beneficence for these children; at least one study shows no improvement or actual worsening as a result. But why then does it preclude subsequent environmental efforts? Had Dr. Bettelheim read several of Dr. Lovaas's reports, he would know that the latter *does* work with these children and, not incidentally, has aided them considerably.

Though the author would no doubt disclaim anything more than a superficial relationship, it is nonetheless true that a major proportion of his ideas on the genesis, maintenance, and treatment of autism are preserved in the basic ideas that guide the operant conditioners. Persons acquire a sense of selfhood and a concept of "I" only insofar as they are able to sense that they control to some extent their own environment. An enormously significant feature of that environment for children are their parents. Dr. Bettelheim is so right when he emphasizes the concept of "mutuality" that must pervade healthy child-parent interaction. I believe, as I am sure Dr. Bettelheim does, that reciprocities lie behind all productive and stable social systems including, most importantly, those between a child and his parents. My review took these points for granted. Other reviews of his book were long, uniformly sympathetic, and explicative of his theory.

Operant conditioners often fall short of sound sociological insight in their descriptions of a relatively rigid and asymmetric, individual-centered therapy. Operant description typically understates the degree to which operant therapy assists the children in entering into reciprocally controlled social exchanges. This is at least the starting point for mutuality, and oper-

ant procedures when applied in a thoughtful manner are extremely effective in initiating it. Given the large number of autistic children now being aided by more or less operant programs, and the growing list of publications stemming from them, Dr. Bettelheim's summary dismissal in some few paragraphs is unwarranted.

It is unfortunate that scientists and therapists who identify themselves as humanists feel compelled to cry "totalitarianism" when confronted by a critical evaluation supportive of a more rigorous, even experimental approach to the treatment of human pathologies. Such charges are simply irrelevant to the animation both of psychoanalytic and behaviorist research.

*C. Gary Merritt
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Licensing Social Workers

TO THE EDITOR:

I should like to call the attention of your members to new legislation, effective July 1, 1969, which requires that social workers

who engage in the practice of clinical social work in California must now be licensed. The new law, the first of its kind in the United States, sets forth uniform professional training and experience requirements for clinical social workers.

As members of your Association know, social workers have long provided help to individuals, families, and groups in such settings as psychiatric clinics, hospitals, correctional facilities, family and child service agencies. In recent years there has been an increasing demand for these services in the private sector. Clinical social workers in private practice now offer individual, family, and group psychotherapy as well as consultation to communities. The new legislation will ensure that the quality of these services remains at the same high level and that the needs of the total community will be met more adequately.

Readers who would like to study this new legislation may do so by requesting a copy of Senate Bill No. 1224 from the Bill Room, California State Capitol, Sacramento, California.

*Charles H. Hurt, M.S.W., ACSW
Encino, Calif.*

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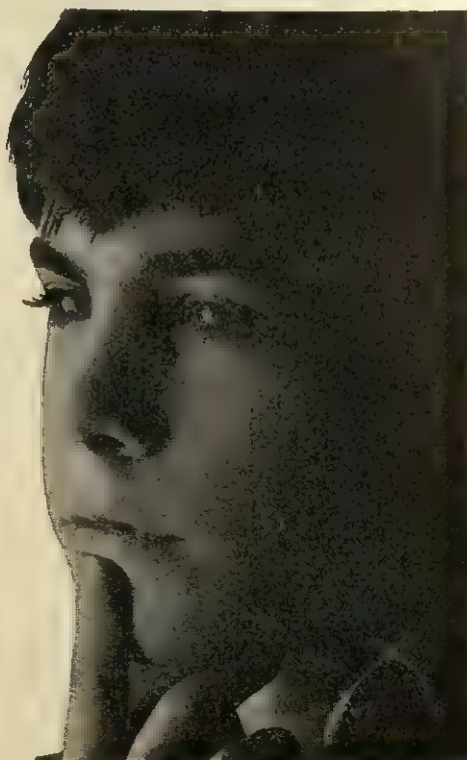
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LETTERS TO THE EDITOR

Bower Responds to Iannaccone

TO THE EDITOR:

A cartoon in the New Yorker several years ago depicts a matronly lady seated in an art museum copying a painting on the wall. Her source of inspiration and creativity is a large animated and vigorous canvas entitled "The Rape of the Sabines" in which Roman men are carrying off Sabine women over the bodies of dead and dying Sabine men. Back in a far corner of this huge canvas, coasting along behind the action, is a little bird. The lady is painting the bird. The review of *Behavioral Science Frontiers in Education* by Dr. Iannaccone (July 1969) seems to have done much the same—painted the bird and avoided the action.

The first 70 pages and the introduction of the book deal with the concept of ego processes and its relationship to building effectively functioning learners. These are followed by chapters on cognitive-affective processes (Nevitt Sanford), preconscious functions in learning (Lawrence Kubie), a learning-teaching paradigm (Barbara Biber), teaching strategies for cognitive growth (Taba), etc. Nowhere in the book is there a discussion of therapy, patients, clinics—the terms are not even indexed. Yet according to the reviewer, "the old dilemma repeatedly emerges. A school is not a hospital, not even an outpatient clinic. Pupils are not patients; only by stretching an analogy are they usefully viewed as clients." I am at a loss to understand the significance or relevance of these remarks to the book.

At another point the reviewer suggests that the authors "carefully seek to avoid authoritarian control of the young." I agree that the authors do seek to avoid authoritarian control of the young. They would also like to abolish poverty and reduce taxes. Yet I have no idea where such ideas are pursued in this book in any major or significant way.

The review also suggests that "the language of the volume frequently denies any attempt of the clinicians to take command of the schools." We would also deny under oath any attempt by educators to take over clinics. How our language accomplishes these drastic takeovers puzzles me.

Along about the second day of a meeting or a workshop one can anticipate someone suggesting, with heavy heart, that the meeting or workshop would have gone better if so and so had been invited or if this group or that group were represented. So in the middle of his review, Dr. Iannaccone laments the absence of teachers and administrators in the list of contributors. If he means presently employed elementary classroom teachers and school principals, he is correct. Nevertheless, he failed to point out that almost all contributors have been or are teachers and many have been school administrators. All are experienced behavioral scientists who have worked many years in learning research and education.

Dr. Iannaccone further laments the lack of contributions from fields of political science, economics, school organization, and the whole range of sociological concepts. To this list, I would add applied mathematics, environmental design, linguistics, genetics, social systems analysis, and computer technology. It's much like the critic who criticized a piano recital because the instrument played was not a violin. It seems to me one reviews what is played or written. Books, like bank accounts, have limits.

If this appears to be an exasperated response to a discrepant, irrelevant, mystifying review, it is.

Eli M. Bower, Ed.D.
Professor, Special Education
University of California
Berkeley, Calif.

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Confrontation at Ortho 1969

EDITOR'S NOTE: *Young professionals, paraprofessionals, and students moved into sessions of the American Orthopsychiatric Association's annual meeting last spring to interrupt scheduled programs and ask for dialogues on what seemed to them the fundamental issues in mental health. Following the meeting, the Association surveyed the more than 1,200 who had been on the program and discovered that, while less than ten percent of the total number of sessions had been disrupted, a large majority of those who did have the experience came away feeling that it had been stirring and mind-opening. Two members of the JOURNAL's Editorial Board here discuss some of the issues raised.*

"You have to shoot somebody, burn yourself alive, do something violent, in order to get any attention at all, however good your cause, or causes, however patient you have been, however well you have put your case. There is an absolute stone wall of indifference. All over the world."

Arnold Toynebee

This statement which appeared in the *New York Times* appropriately enough on the last day of the 1969 meeting of the American Orthopsychiatric Association would seem to be an accurate distillate of the zeitgeist of today's youth. Most of us fancy Ortho as representing mental health's progressive wing. It must have come as a shock to many then, that a group of young professionals in the mental health field should turn against their loving parents and engage in a series of radical actions at the annual meeting. Members in the business meeting agonized over whether or not to admit students and/or "sub-professionals" to membership. Certain

members expressed alarm at the prospect because it might dilute the "high professional standards" of the organization. Ironically, at the same time in another room, a "radical caucus" was hurling charges of what these same high professional standards had brought about: in the view of the young professionals, the mental health professions and their organizations like Ortho had become tools of the establishment for the convenience of the rich and for the oppression of the poor. A number of more general themes also emerged:

1. The first was that current concepts of mental health are largely invalid in that they see all behavior as endoge-

nously determined rather than largely a normal reaction to an abnormal environment. This results in the outrageous absurdity of someone like Bruno Bettelheim explaining the behavior of University of Chicago students in terms of their individual psychodynamics rather than in terms of the social realities in the university and society. This plays into the hands of the power structure and the mental health field becomes a force for the preservation of the status quo.

2. The second theme may be summed up as "society is sick, therefore sane people ought to be sick, and any profession which tries to adjust people to a sick society is a tool of the power structure." A specific example of this as stated by one girl was that psychiatrists in Vietnam should not be trying to get psychiatric casualties back into their units, but rather to get all the GI's to become psychiatric casualties, and thus to end the war.

3. The third was that though the Ortho program was largely about youth and its unrest, youth itself was not represented on the panels. From the titles of the panels and the abstracts of the papers, the radicals had adjudged that the participants didn't know what they were talking about, and youth by hook or by crook was going to present its side of the story.

The tactic for articulating these three themes was a sort of modified "sit-in" in which a group of demonstrators would arrive just as a session was getting started and, by seizing the P.A. system, take over the meeting. The radical caucus was, of course, not really a caucus in any unified sense and throughout the meeting new splinter groups (black caucus, brown caucus, women's liberation cau-

cus, etc.) kept appearing. Those disrupting the meetings seldom numbered more than 10, able by hit-and-run tactics to throw several hundred people and several sessions into complete chaos.

But the radicals had a message and it was heard at the meeting. We in Ortho were shaken from our complacent position as mental health's left wing and will be forced to reexamine our concepts and postures. The radicals are to be congratulated for making Ortho 1969 a great meeting. But though we must hear their message, one thing is clear—the process of change will not come from the radicals, only its momentum. Whatever we in the establishment do, we will continue to be vilified and rejected, perhaps rightly since we have by our success made our compromise with the status quo. The radicals are rather like catalysts in a chemical reaction—a bitter, passionate, boorish but beautiful minority, the conscience of our times. But move we must. The war in Vietnam goes on, children starve in Mississippi, the Defense Department has become a Frankenstein stealing the food, health care, education, and fathers from the children of this country. Ortho cannot any longer afford to stand pat on these issues; we must take action. If we really believed what we talk about in our meetings, next year's would take place in the Pentagon under less decorous circumstances or at least in Washington with us lobbying instead of listening unactively to papers. The establishment can ignore a small group of noisy students but an outraged professional group is not so easy. One Dr. Spock is worth a hundred thousand students.

*John S. Werry, M.B., CH.B.
Editorial Board*

The Paraprofessional and the Use of Confrontation in the Mental Health Field

The use of confrontation techniques by paraprofessionals in the mental health field is part of a broad range of movements aimed at creating major reforms in our society in our time. The general distress about our social institutions and what they do to the individual has resulted in a multitude of "encapsulated revolutions" directed towards social change.

These contemporary revolutions share certain features. For one thing, they have often attacked structures closely related to the life of the individual rather than those which would be the logical targets for sweeping change. In contrast to classic revolutionary strategy, which attacks crucial political structures in order to produce massive change quickly, the current-day strategy is aimed most frequently at health, education, and welfare institutions. The goals of these encapsulated revolutions seem to involve an increase in the relevance of institutions to the lives of the people involved with them, usually through efforts to increase the participation of their clientele in the structure and administration of the institution.

Another shared feature has been that the activators * of these revolutions have

largely tended to be people without previous experience in politics, organization, and the manipulation of power: the young, the poor, and the black. The institutions they attack have in common the usual institutional tendency toward stability and the preservation of the *status quo*. Because of this essential conservatism, changes in the institutions almost always entail a crisis. The techniques used by the activators to produce a change-inducing crisis range from orderly democratic process to violent revolutionary tactics, and the intensity of the crises varies, but some degree of crisis seems inevitable in the process.

Common to most of these movements also has been some division of viewpoint and strategy within the ranks. Or to put it differently, "revolutions" can be at more than one stage in their own development at any given time, with different goals appearing simultaneously (but dysphasically) or sequentially over short periods.

The civil rights movement of this decade, for instance, began as a drive towards integration. As a result, black people are increasingly participating in the integrated life of the United States of America. Their political power is

* I have chosen to use the term "activators" in this paper, rather than "militants" or "agitators," because it carries an operational connotation. "Activators" create change-producing action.

growing, as elections in some of the cities indicate.* But at the same time that this is appearing, a push is being made by some black militants in the urban ghettos to develop separate black enclaves as a source of political strength. These two strategies may represent not only different groups of people or different ideologies but also different targets. Black separatists may be more concerned with changing the social structure of the black community vis-a-vis itself as a step in the total political and social process. Integrationists may be more concerned with the political struggle occurring at the present interfaces of black and white America. And at certain moments the immediate goals of the separatist revolutionaries conflict with the immediate goals of the integrationist revolutionaries. But their ultimate goals are not substantially different. Both are concerned with the full participation of black people on an equal footing in the sociopolitical process; this step will be necessary for the actualization of any political ideology now espoused by either group. This phenomenon of diverse goals is found in other areas of protest and action as well.

Lastly, it has been a common phenomenon for the activators in any area to see all current movements as inter-related, with similar sources and targets. The tendency in the heat of a revolutionary atmosphere is to "spread" problems and see them as connected. The fact is, however, that problems, issues, and goals in different areas, while they may be partly related also may be antithetical. The attempt to see all contemporary "revolutions" as part of one grand design is apt to create a series of

confusions, making a clear analysis and effective action in any one area much more difficult than is necessary.

With this much preliminary, I would like to consider the problem of confrontation in the mental health field, treating this area as one with its own issues, history, and goals. Certainly confrontations in this field, and the movement behind them, share general features with such phenomena in other areas. They are characterized by attacks on institutions that are close to human experience but not politically expedient, because the mental health sector holds little meaningful power in American society and is a low-yield area in terms of major social change. They generate crises in their challenge of institutions which, while not corrupted, are certainly inert and slow to change. And the confrontations are created, often, by activators who flood the issues with other current concerns—as though a change in the structure of social service institutions would bring an end to the Vietnam war, for instance. It is well to remain cognizant of this broader picture and of the features common to protest and confrontation across many content areas. At the same time, this area has its own issues, history, goals, and problems. It has its own particular features of inertia and thrust, its particular target populations, and its own questions of core necessities in training and skills. Therefore, for the rest of this paper, I will consider the mental health field in its own context, with special attention to the role and use of paraprofessionals within it.

* This is not to say that the job is finished. But it is an indication of progress, in my opinion.

A discussion of paraprofessionals in the mental health field cannot be clear without a brief reminder of the circumstances surrounding the use of paraprofessionals. With the gap between mental health needs and the manpower available to fill them increasing rapidly, the use of paraprofessionals was seen as a way of filling that gap. For many professionals, a very important major assumption was implicit in this strategy: that we could maintain intact the traditional conceptualizations of mental illness and treatment, simply fitting the nonprofessionals into the already existing structures of delivery of service. The nonprofessionals would take on the functions which did not require trained manpower, freeing the professionals to spend their time in areas which utilized their professional talents. Since the chief problem was seen as lack of manpower, it was assumed that this use of nonprofessionals would make the existing delivery of services more effective.

But the inclusion of paraprofessionals in the existing structures of delivery of service brought to a head a bipolarity* of approaches to mental illness which was already incipient in the field. At the one pole (which attracts the activators) is the theory, influenced by sociological thinking, that sees pathology as coming from the "outside in." The axiom of this ideology is that people respond to their environment, and if the environment changes, people will change reciprocally. This approach has influenced large interventive programs oriented toward providing jobs, manpower, training, youth camps, etc. It forms the backbone of the community organization emphasis. The assumption is that while there will al-

ways be individuals with problems which will require traditional, individual mental health interventions, major change in major social ills will affect most individuals for the better. This concept, the product of twentieth-century thinking, which sees the individual in his contexts, both interpersonal and impersonal, stands opposed to the traditional concept.

The traditional concept, built on a nineteenth-century model, concentrates on the individual very much delineated as a separate human being. He is seen as a person influenced by his surroundings, but a person who, like an epic hero, must conquer his world. This concept has moved towards a consideration of the larger social ills, but approaches them with the conceptualizations and techniques of individual treatment. Some of the techniques have been adapted to the purpose of working with social phenomena, but the basic conceptualization remains. People are seen as responding to internal problems rooted in their past rather than as responding to present contexts. Needless to say, the mental health establishment tends towards this pole. As a result of this bipolarization, the establishment sees the activators as trying to repair a watch with a hammer. The activators see the establishment as trying to sweep back the tide with a broom.

This polarity has been significant in the organization and training of paraprofessionals in the field.

The "sociological" approach has had little difficulty including the paraprofessionals. The community organizations could readily broaden their organizational charts and find relevant places for

* I stress the bipolar nature of these conceptualizations for the sake of clarity. I am aware of the middle grounds.

indigenous workers, utilizing their skills and life experiences almost from the beginning without the need for very specialized training. The paraprofessionals, on their part, found in community organization a truly meaningful area of involvement. In this area they were not handicapped by their lack of traditional training. Community organization made sense, was easy to relate to their previous experiences, and was oriented towards their immediate, perceived needs.

The paraprofessionals fit very well into the strategies proposed by community organization theorists. One of them, Alinsky,¹ presented the problem in stark simplicity: Poverty=powerlessness=social illness=mental illness. Breaking this equation by increasing the power of the poor becomes the major goal of many community organization practitioners. Both the professionals and the paraprofessionals in the community organization segment of the mental health field are ideologically activators; they are committed to helping the community of the poor become organized and to have a voice in their dealings with mental health and social institutions. The paraprofessionals here see the possibility of upward mobility within their field because in community organization structures they can move into supervisory positions. And they can see themselves ideologically as members of a loose association of activators enrolled in the other "revolutions" of today's society.

The paraprofessionals who were absorbed into the more traditional mental health frameworks found themselves in a much more difficult position. They were brought in to help fill a manpower gap as untrained workers under a conceptualization that said that only the

trained could heal. But the necessity of using paraprofessionals gave rise to the fantasy that somehow, along with the experience of being poor and black, comes the knowledge of how to treat the poor and black. The poor and black could be seen as possessing empathic ability to heal the poor and black, and this overcame the problem of their lack of training on a theoretical level.

On a practical level, however, problems arose. The paraprofessionals, largely untrained, were given the responsibility for treatment but not the knowledge of how to do it. The professionals remained in their offices, behind the lines, retaining the "knowledge" of interventive approaches and the supervisory power. One compromise theory reached was the concept that the supervisors have knowledge but cannot implement it because they do not have the experience of being poor and black. Therefore, the poor and black are seen as implementing the professionals' recommendations under their supervision. But from the paraprofessionals' point of view, they were being asked to perform professional jobs without professional training and with little or no possibility of training or advancement. And their closeness to the roots of socially caused mental health problems could not be brought into full play within the traditional, intrapsychic conceptualizations.

The two poles of the conceptualization of psychopathology and the delivery of mental health services have kept the friendliness of neighboring nations with clear-cut frontiers. Each one has its specific organizational structure, staff, way of providing services, and sphere of influence. In some cases these approaches are competitive within a single agency,

but in most cases they are separated. Occasionally one finds a tentative collaboration, and only occasionally, a meaningful integration into one approach to service.

The paraprofessionals within the community organization component of services have become easily assimilated. But those hooked into traditional services see themselves as doing frustrating jobs at the bottom of the professional ladder with no chance to advance. The "white" professionals in supervisory jobs become the target of their frustration, and they find themselves greatly attracted by the sociological orientation, which they see in operation in other areas.

Caught in this untenable position, the paraprofessionals have tended to develop their own theory of mental illness, which can be stated as follows: Improving the self-concept is one solution to the problem of mental illness. If a poor sense of identity has been developed from the derogatory ways society responds to the black and poor, then "Black is Beautiful" becomes a unique and necessary concept in the delivery of mental health services.

This concept, quite different from the traditional concepts, ties the paraprofessional in traditionally oriented services to the professionals and paraprofessionals of the "sociological" persuasion. The concept is basically correct, but it has been generalized to the point of being seen as a panacea for all illness.

As with other current encapsulated revolutions, the struggle of the professionals and nonprofessionals of the sociological orientation with their counterparts in the mental health establishment is fed by many sources. Some of these are outside the field, others are

inside. And some of the inside sources are related to a constructive approach to changing the delivery of services and making it more relevant.

The many sources make it difficult to differentiate issues clearly when conflicts arise. Some struggles, for instance, are simply structural, springing from the inherent difficulties of trying to include a large mass of untrained people in a field that was clearly structured along hierarchical professional lines. But when we look at these conflicts, we see that they have rarely been couched in these terms. The hierarchical struggle has been flooded by the black revolution. There is nothing new about conflicts between labor and management—between the front line and the GHQ. But this particular one can take on a new and attractive dimension. Because the paraprofessionals are by definition untrained, poor, and black, the professional supervisors are seen as rich and white. The activator (of whatever color) can therefore fly the flag of the black revolution. By implication, the activators within the mental health field speak for the entire black community, which may not be involved at all. And the mental health professional comes to represent conservatism on all levels. He is seen as a conservative in the mental health field and in terms of the economic revolution and the black revolution.

This confusion becomes particularly bothersome because the activators espouse a series of ideologies which spring from traditional liberal and/or socialist reform movements, which are espoused also by many members of the white professional establishment. But the professionals find themselves confronted with ideas they agree with, now hurled at them as though they were against these

ideas. The confrontation is couched in such a way that in order to defend the ideas they believe in, the white professionals must attack themselves.

I think that the present state of crisis in the mental health field can and should produce valuable change, and not just struggle. But this can happen only if we see the current struggles, including the technique of confrontation, within their framework; that is, the conflict between traditional and sociological approaches. We must also clearly differentiate the boundaries of the struggles.

When confrontation is used as a technique in the mental health field, many confusions arise. One of these centers on the importance of the content of the confrontation.

Representatives of the establishment tend to address themselves to the content of the confrontation, suggesting approaches for solving what they see as the problem. But for the activator the struggle may be seen as an exercise in the experience of power. In such cases, the confrontation is the end in itself, and the content is simply an irrelevant component of the training device. As a result, when the establishment addresses itself to the content of the confrontation, the activator experiences the establishment as either "copping out" or trying to take over.

Furthermore, the activator who has accepted the technique of confrontation tends to dismiss, for the time being at least, the value of other techniques. The tools which have been used by the establishment fall under suspicion. They are seen as techniques which have been used to detour, rather than cause, change. Activators, therefore, tend to be anti-knowledge and anti-intellectual; attack-

ing the techniques which have been developed by the mental health field has become part of the field of confrontation. The establishment, reciprocally, sees the activators as "in danger" of using confrontation as an end in itself. They suggest that a strategy which is adequate for producing change-inducing crisis may not be adequate for the development of the goals toward which change should be directed.

The establishment also sees a problem in the indiscriminate use of confrontation technique as the only weapon in the arsenal. When a goal could be achieved by differentiated study of the situation, leading to negotiation and satisfactory resolution, the technique of confrontation tends to crystallize polarization. The result is escalation without possibility of satisfactory resolution. Opposition stiffens, which leads to renewed confrontation.

When I look at the present crises of the mental health field, I see them as results of the struggle between two irreconcilable approaches. The basic conflict is not struggle between professionals and paraprofessionals. It is a conflict inherent in the attempt to introduce paraprofessionals into the delivery of services while trying to maintain the traditional conceptualizations of mental illness, which carry the implicit idea that non-professionals cannot heal. The situation is a paradox, and the answer to any paradox can only be another paradox.

But if we approach the mental health field as uncharted territory, a solution can be found. The mental health field now is caught in an ideological dichotomy. On one hand, the individual is seen as an isolated entity. His intrapsychic life carries the introjects of his family, institutions, society, culture, and

mores. On the other hand, the influence of the *present* environment with which the individual must constantly interact is emphasized.

This dichotomy of conceptualization requires a separation of services, some directed towards "the individual," some towards his "environment"; only rarely are the two types integrated.

It is possible, however, to conceptualize the individual as indivisible from his ecology. This conceptualization springs from systems theory, and it makes an integrated delivery of services possible. The individual is seen in his contexts, both interpersonal and impersonal, acting and reacting in accordance with feedback processes. Changes occurring in the system will affect its members in some way, and vice-versa. The intervener, accordingly, selects his point of entry depending upon his goals for change. The smallest unit of intervention in this model is the family, though the method of treatment may be individual sessions. Interventions vary, but the conceptualization always includes the systems of which the individual is a significant subsystem. The understanding of systems dynamics yields a great many possible strategies for change.²⁻⁵

In conclusion, let me repeat that there is no doubt that the mental health field needs to change in order to deliver better services to our clients. As things stand now, the middle class are being treated by the trained, while the poor are seen by the untrained. Even when we work under the aegis of a more correct ideology, we tend to crystallize this system.

As a first step towards comprehensive change, we need to develop a clear diagnosis of what the problems are. When this has been done according to an

ecological conceptualization of etiology and treatment, we will have to develop differentiated strategies for attacking the problems. When this has been done, we will need to select and train people who will be competent to execute these strategies.

The word "competent" becomes the key. We need to train people, both the academically credentialed and the academically noncredentialed, so that they can do their jobs properly.

The word paraprofessional has come to be associated too much with the lack of academic credentialization and too little with the attainment of competence. But with adequate training, the paraprofessional can become truly expert.

For instance, the nonprofessional who is to be used in a program to teach mothers to stimulate their babies' cognitive development by playing with them in growth-inducing ways will have to be trained in infant development, teaching techniques, and the differentiated methods of stimulation to be used.

The nonprofessional who will be working with families will need a knowledge of the systemic characteristics of families, the problems of interpersonal communication, and so forth, as well as a knowledge of the institutional and community systems of support available to families.

The nonprofessional who is to work within the school system will need a knowledge of child development, children's cognitive styles, and classroom dynamics as well as knowledge of the school as a system.

The nonprofessional who is to work as an advocate, helping families in the community in their dealing with institutions which are a source of both services and control (hospitals, welfare, housing, and the courts, for example) will need a

thorough knowledge of the bureaucratic procedures through which services come, as well as a differentiated knowledge of the needs of his client families.

Obviously, the mental health field's system of credentialization will have to be reviewed and modified to accommodate these paraprofessionals. This will also force us to review the training of those who are currently credentialed. The contributions of professionals will not be nullified. But the training of all mental health workers, those who are currently credentialed as well as those who are not, will have to become much more differentiated and solution-oriented, so that we can make the minimal and specific interventions which will be maximally helpful to our clients.

Changing the social institutions which impinge harmfully upon our clients will remain one of the legitimate tasks of both paraprofessional and professional mental health workers. And confrontation will remain one of the techniques useful for jolting those institutions in the direction of change.

Within the mental health field, this is a time of great opportunity. The community mental health concept has made us aware of the needs of a large population, and this is forcing the mental health field to look at itself and its concepts of illness and the delivery of services. We cannot help seeing how sparse our theories of the process of change are, and how limited we are in strategies for producing useful change. This realization will push us to better conceptualizations, which will make it possible for us to help our clients much more effectively.

The inclusion of paraprofessionals, which began as a stopgap designed to increase the effectiveness of the profes-

sionals, has already fractured our clear-cut structures of well defined areas of concern and easy answers. The inherent impossibility of absorbing these paraprofessionals without changing our conceptualizations of illness and treatment will push us further towards new solutions.

As for the confrontation technique, it has been used throughout American history as a useful tool for inducing change, and it will continue to be used. But it is not a solution to all problems, particularly when used in an undifferentiated manner. It attracts attention, particularly within the sedate and sometimes staid mental health field, because of the intensity of its noise. But it can also produce static, which drowns communication. We must reduce the static of undifferentiated, power-play confrontations and grasp the opportunity confrontations offer to look at the mental health field with an eye to improving our helping capacity. We must be concerned with a different type of confrontation, the confrontation of ideas, and search for helpful resolutions.

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THEORY AND REVIEW

TEACHERS AND DIFFERENCES

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The success or failure of the most carefully planned, the most adequately financed educational programs may depend solely on the nature of the encounter between pupils and teachers. Hidden feelings and prejudices in the teachers impair success as much as de facto lack of respect for individual differences in the classroom.

After almost 15 years of experience with desegregated schools and with the upgrading of schools which are still de facto segregated, we are arriving at a moment of truth. Surveys by Coleman,³ The U.S. Commission on Civil Rights,¹³ and others demonstrate that our many efforts to improve the situation have yielded, at the very best, modest results. In the debate which this recognition has set off, the emphasis is again on new programs, new experiments, changes in school administration, more money—all the things we have already found cannot do the job alone. At the same time, such a vital issue as the face to face encounter *as human beings* between teachers and

students in classrooms is hardly ever mentioned or considered. Yet the success or failure of a carefully planned program may depend solely on the nature of this encounter between people with widely divergent needs and emotional makeups but a common goal: learning. It is the purpose of this paper to emphasize this aspect of teacher-student interaction.

In their discussion of the relationship between psychotherapy supervisors and trainees, Ekstein and Wallerstein⁴ distinguished between the "learning problem" (what is to be learned) and the "problem about learning." The "problem about learning" results from the different personalities and the "differing

ways of learning and teaching which each student and supervisor bring to their joint endeavor." These idiosyncrasies and predilections determine what will be learned and how it will be learned. The solution of the "problem about learning" depends to a large degree on the interpersonal relationship which evolves between student and teacher and thus affects the outcome of the "learning problem."

The problems about learning encountered in desegregated and still segregated schools are remarkably similar to the problems encountered in many other schools, now that students increasingly assert themselves and refuse to be indoctrinated in the same way their parents and many generations before them were. Even the students who submit to teachers no longer necessarily agree with them, setting up a learning relationship which is totally devoid of mutual interpersonal respect. From 449 gifted students in a private school run by a well-known university, Getzel and Jackson⁷ selected 28 students who were in the top 20% in IQ but not in creativity, and 26 students who were in the top 20% in creativity but not in IQ. When these two groups were asked which of 13 student traits teachers preferred, the agreement was almost total—the correlation was 0.98. But neither one of the groups thought that the traits preferred by teachers were likely to bring success in life. Both groups wanted success equally much, but disagreed fundamentally on the way to achieve this goal. The high IQ students were willing to go along with the teachers to succeed, while the high creatives most emphatically refused to do so.

In discussing these research findings, Friedenberg⁸ identifies a group of stu-

dents whom he calls the "subjectives." Friedenberg defines subjectivity as the "capacity to attend to and respond to one's inner life and feelings, to the uniquely personal in experience, to interpersonal relationships." These subjective students have very little use for school, but teachers and schools alike have even less use for these particular students.

Schools are also uninterested in their students' developmental dilemmas. The curricula and academic requirements in junior high schools generally ignore the psychological burdens many students are carrying while they are going through the changes of puberty. High schools ignore the adolescent quest, as eloquently described by Friedenberg⁶:

They want to discover who they are; the school wants to help them make something out of themselves. They want to know where they are; the school wants to help them get somewhere. They want to learn how to live with themselves; the school wants to teach them how to get along with others. They want to learn how to tell what is right for them; the school wants to teach them to give responses that will earn rewards in the classroom and social situations.

Now puberty is occurring earlier and earlier; quite a few students enter puberty in the fifth or sixth grades. These children are set apart from their age-mates not only physically and emotionally but also socially. Yet in the name of the blessings supposedly ensuing from keeping children of the same age together, regardless of the circumstances, teachers and schools consistently fail to offer any other alternative to these youngsters than to stay where they are and to do the best they can. If this "best" is not up to teacher expectations, these children then become "discipline" or "learning" problems.

These few examples illustrate the vast

differences there are between students in all types of schools, as well as the reluctance or inability of the schools and teachers to flexibly adapt themselves to their students and to solve the mutual problems about learning. As Fantini⁵ points out: "Pupils are judged on how well they fit in—whether the mode of the school be folded hands, quiet in the halls, short haircuts, or an irrelevant curriculum with teaching methods that fail to diagnose the learning style of individual pupils. . . . The schools are acting *upon* raw material; if the material resists shaping and molding it is discarded and labeled defective."

Where teachers and pupils have widely divergent backgrounds in addition to other differences, the teachers' intolerance for individual differences becomes even more apparent. A few years ago, while helping to teach a university credit course for graduate teachers in a poverty area, I discovered that none of the teachers in the class, who were all white, had ever visited the homes of any of their students. Though some of the teachers had taught in their present schools for a number of years, they considered such visits totally irrelevant to their professional tasks. Furthermore, they were sure that it would severely embarrass their students if the teachers were to observe personally all the inadequacies of the students' homes. It further emerged that none of the teachers had tried in other ways to acquaint themselves with the subcultures of their students.

Following our class discussion about this, the youngest teacher in the class spontaneously made a visit to the home of a Mexican-American pupil whose family lived in a tarpaper covered basement (the rest of the house had never

been built). In an almost starry-eyed fashion she reported to the class how cordially she had been received, how she was the only one who had been somewhat embarrassed at the start of the visit, how clean the house was, and how much she had learned about the family.

After she was through the rest of the class reacted with intense anger. Her reaching out for the family of a student was called "un-American." In subsequent discussions the teachers in the class continued to resist seeing any possible connection between their own attitudes and the high dropout rates in their schools. They stressed that they had worked hard and done everything they knew to do to reach their students and to "convert them to the American way of life." The high dropout rate in spite of their devoted teaching efforts proved to them the truth of their convictions that they were working with mentally and morally inferior student material.

Their inability to overcome this formidable learning block and their failure to solve this problem about learning illustrates the problems any new program will—and has—run into when it is to be implemented by live teachers. Most teachers teaching in our schools today have either been trained in the "melting pot" era or were trained by a faculty which was the product of the melting pot. Thus the basic goals which the teachers have are still the ones from the early years of the industrial era, when thousands of immigrants from many countries poured into the United States. The goals then were to make homogeneity out of diversity. Unfortunately, or fortunately, times have changed, and new and very different

goals are required in the postindustrial era. Almost invariably, teachers are sympathetic to the need for change, but when it comes down to action they want a change only in methods, not in goals. Paul Goodman⁸ blames this inability to adapt on the teachers' training. Kenneth Clark² asks whether the selection process involved in training and promoting educators weeds out the teachers who can be bold, creative, practical and have the ability to demand and obtain the things necessary for effective teaching and education.

The Coleman⁸ report emphasized that student performance correlated positively with the teachers' social class of origin, the teachers' verbal ability, and the quality of the teachers' education. However, the better teachers were also least likely to want to teach in predominantly Negro or blue-collar schools. The majority of white and Negro students polled in teacher's colleges preferred to teach in academically oriented schools. Is this a tragic result of the heavy emphasis on "method" in American teachers' training and of the almost total neglect of the dynamics of interpersonal interaction with children in the curriculum in teachers' colleges? Student teachers are taught to be professional technicians rather than to be professionals. When they emerge from their colleges, they have become abstract beings, "the teachers," who all dutifully proclaim their love for all children, who know that all children are created equal (there really isn't even a difference between the sexes—that would be unconstitutional), who will nevertheless deal with each "whole" individual student, who will never carry a grudge against any student, who will never get angry, but will always be patient, wise,

unprejudiced, just, calm, positive, and optimistic.

Is it any wonder that these human robots, if they do not manage to tear themselves loose from their shackles, find it hard to adapt to live students who do not fit the mold the teachers have been taught to prepare for the students? The very existence of such students is a grave threat to the professional identity of many teachers. These students, therefore, in some way have to be eliminated or avoided altogether, always in such a clear way that only the student can be blamed.

Thelma Catalano¹ points out that failures in classroom communication on a human level invariably lead to the reduction of learning to "the lowest common denominator for all concerned." She stresses, like Ekstein and Wallerstein,⁴ that true communication between any two human beings is impossible without each of the persons opening themselves to learning *from each other*. If genuine communication is to come about in a classroom, the teacher must be willing to change and be influenced as much by his students as the children must be willing to let themselves be influenced by the teacher.

Kohl⁹ describes this process in the following way: "I had to enlarge my vision as a human being, learn that if the complex and contradictory nature of life is allowed to come forth in the classroom there are times when it will do so with a vengeance." The teacher must be completely honest, not only with and about himself but about the world in which the teacher and the students live. This is particularly difficult if the students' firsthand experience with the gruesome social and economic realities of life in contemporary America

do not dovetail with the sugar-coated view of this country to which many teachers and most certainly their classroom textbooks cling.

We know from many sources how many American youngsters object to this type of intellectual dishonesty and how much they are alienated from society by being forced in the schools to regurgitate Madison Avenue versions of a reality, which they know only too well from TV if they have not had firsthand experiences with it. Kohl¹⁰ states about this: "There is no more thorough way to keep alienating the young in our society than by continuing to feed them myths and lies about who we are when the children know perfectly well that we don't believe it ourselves."

The power of teacher's hidden attitudes has recently been documented by Rosenthal and Jacobson.¹² When it was conveyed to teachers that randomly selected children in their classrooms had tremendous potential for intellectual growth, these children's IQs increased dramatically in comparison to a control group. It was found that the most "Mexican-appearing" children with dark complexions gained the most—suggesting that for these children the teachers' original expectations were lower than for other groups of children.

Significant changes in American schools can be made only to the degree teachers can be persuaded to recognize their own hidden attitudes and prejudices. They must learn to respect their own and their students' humanity and individuality. If they do wish to make these changes, teachers will need help in getting to know themselves and true current social reality

and in acquiring genuine trust in their students. This will require teachers' colleges to radically revise their curricula and for the first time to allow the social reality of live students with individual differences, unique internal struggles, and social realities inside the doors. Until this is done, or until teachers undo after graduation what was done to them in their colleges, many expensive "new" programs will go down the drain.

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RESEARCH

BIOLOGICAL AND SOCIAL CORRELATES OF STATURE AMONG CHILDREN IN THE SLUMS OF LIMA, PERU

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A study of a sample of children with contrasting stature from the slums of Lima, Peru showed that the short children were more likely to have shorter mothers, who had had more pregnancies, less years of schooling, and a greater number of marriages. The results, reported here, suggest that although differences in stature might reflect differences in nutritional background, they are also likely to reflect differences in other important biosocial factors.

Recent studies on the effects of malnutrition in early life on cognitive⁴ and neurointegrative⁵ development have used contrasts in stature as the sole procedure for contrasting nutritional background in children. This methodological practice is based on a substantial body of evidence indicating that nutritional conditions in early life greatly influence body size.¹² Despite the conclusive evi-

dence that early nutrition affects stature, however, the use of stature as the sole index of nutritional background still involves serious methodological problems, especially in studies assessing the probable influence of nutritional background on psychological development. There is considerable evidence to suggest that children differing substantially in stature may well differ also in other biological

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and/or psycho-social variables which, independently of nutrition, could also affect psychological development. Groups of children of contrasting stature might show psychological differences resulting from nutritional factors, from other biological and psycho-social factors, or from the joint influence of various combinations of these factors. It would be misleading, therefore, to select nutrition as the only determinant of the psychological differences.

A recent illustration of a study in which such issues are raised is provided by the research of Cravioto, Delicardie, and Birch,⁵ in which tall and short Guatemalan Indian children from 6 to 11 years of age, living in a rural village, were compared on a test of neurointegrative development (requiring matching of forms on the basis of information from different sensory modalities). The tall children performed significantly better than the short group, suggesting the possibility that nutritional deficiencies of the short children accounted for their poorer test performance. Aware of the fact that the stature differences might be associated with factors other than nutrition, these investigators attempted to evaluate the possible role of parental stature and of differences in rate of maturation. In addition, they were concerned with the possible influence of various socioeconomic, educational, and other environmental factors on intersensory test performance. In this connection, they also tested a control group of tall and short, upper-middle-class, urban children and obtained their parental heights. Moreover, information on the environmental background of the rural children was also obtained. Their results indicated that parental height was not significantly related to children's

height in the rural group, although there was a slight trend in this direction for fathers' height. In the urban upper-middle-class group, however, fathers' height was significantly related to children's height. This comparison was taken as suggesting that for the rural children variations in stature are determined more by nutritional variation than by genetic endowment, whereas the opposite is true in the urban upper-middle-class children. Since there were no significant psychological test score differences between the tall and short urban children, the case for nutritional influences on the contrasting test performance of the tall and short rural groups was seen as strengthened.

Most of the socioeconomic and environmental characteristics assessed in that study did not differ significantly between the tall and short village children. However, there was a rather marked difference in the amount of maternal education of these two groups, in favor of the tall children. While, as suggested by Cravioto et al., it is certainly true that the better educated mothers may have provided a better nutritional environment for their taller children, in the view of the present writers, they may well also have provided more psychological stimulation and opportunities for learning, which in turn may have positively influenced the test performance of their children. Thus, it is quite clear that one still can have no assurance that the relationship between stature and psychological test performance was mediated solely through nutritional differences.

There are a number of other correlates of stature, reported in a variety of different studies, which would need to be controlled or otherwise taken into account if one were to attempt to use

stature as a measure of nutritional history, particularly in research on malnutrition and psychological development. In large-scale studies involving wide ranges of population variations, it has been found that stature, various indices of intellectual development, socioeconomic status, and general conditions of physical and mental health tend to correlate positively with one another.^{9, 10, 16, 25} At the same time there is considerable evidence to suggest that among lower-class families, the factors of increased age, high parity, and poor physical condition of mothers are detrimental to the child's intrauterine and later physical growth.^{7, 21, 26} Other research suggests that these same variables heighten the risk of central nervous system damage during fetal growth or at birth^{8, 17} and that there is a relationship between birthweight, a measure of intrauterine growth, and later intelligence quotient scores.⁶ Thus, the same prenatal or paranatal factors which tend to produce reduced physical stature may also affect intellectual development adversely, quite independently of any malnutrition which might occur subsequently.

It was the purpose of the present research to explore further some of the

problems involved in the utilization of contrasting stature groups as a means of identifying children with different nutritional background, particularly in studies concerned with the influence of malnutrition on psychological development. More specifically, this research was concerned with the degree of association which might be found between extremes of stature and some of the biological and social factors associated with or capable of influencing intellectual development, within a sample of lower social class children from a population where malnutrition is endemic, namely the slums or "barriadas" of Lima, Peru. The variables of major interest included maternal height, age, and parity; medical attention at childbirth and birthweight of child; maternal education, family size, family stability, and financial income.

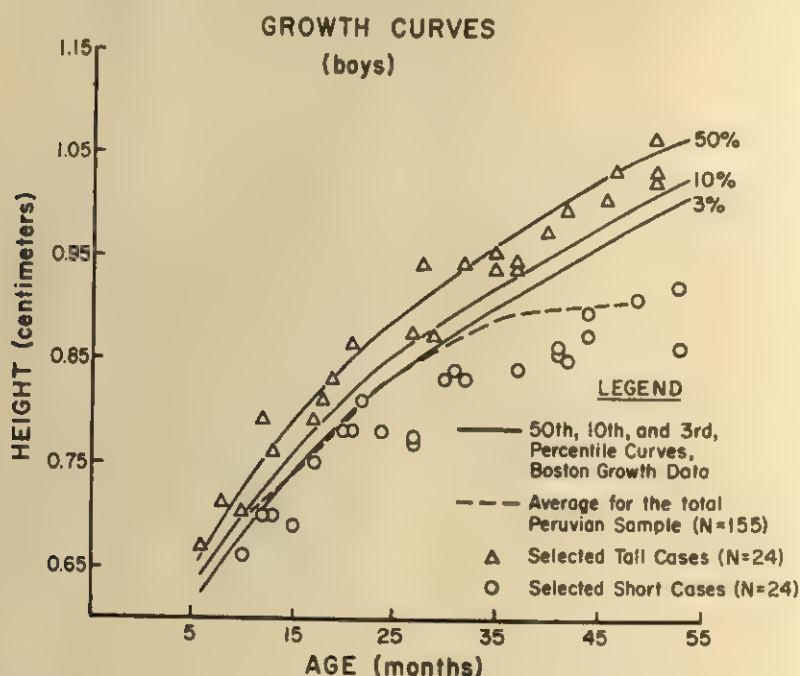
SUBJECTS

Two groups of 48 children from 6 to 53 months of age were selected from a population of 289 children attending seven day care centers in Lima. These centers, run by various charitable organizations, care for the preschool children of working mothers living in the slums. All centers provide adequate care for

Table I
MEAN AGE OF TALL AND SHORT CHILDREN BY SEX AND AGE INTERVALS
(age in months)

AGE Intervals	TALL			SHORT		
	Males	Females	Both	Males	Females	Both
6-17	10.67	11.67	11.17	12.16	12.00	12.08
18-29	23.67	23.33	23.50	23.50	24.16	23.83
30-41	36.00	35.00	35.50	35.33	35.33	35.33
42-53	48.00	47.50	47.75	47.50	47.14	47.33
TOTAL	29.58	29.38	29.48	29.62	29.67	29.65

Figure 1



the children and give them two well-balanced meals a day.

The two groups of children, equally divided by sex, were selected to represent extremes in stature. In each sex subgroup, the samples of tall and short children were equally distributed into four 12-month age intervals, from 6 to 53 months, by selecting the six tallest and the six shortest children in each age interval.

TABLE 1 presents the mean ages for the four subgroups throughout the age intervals.

FIGURES 1 and 2 present the height-by-age curves for males and females for the total sample measured, as well as

the curves of the fiftieth, tenth, and third percentile of the Boston Growth norms from the Stuart and Meredith* data. The cases selected to represent the tall and short groups are also indicated.

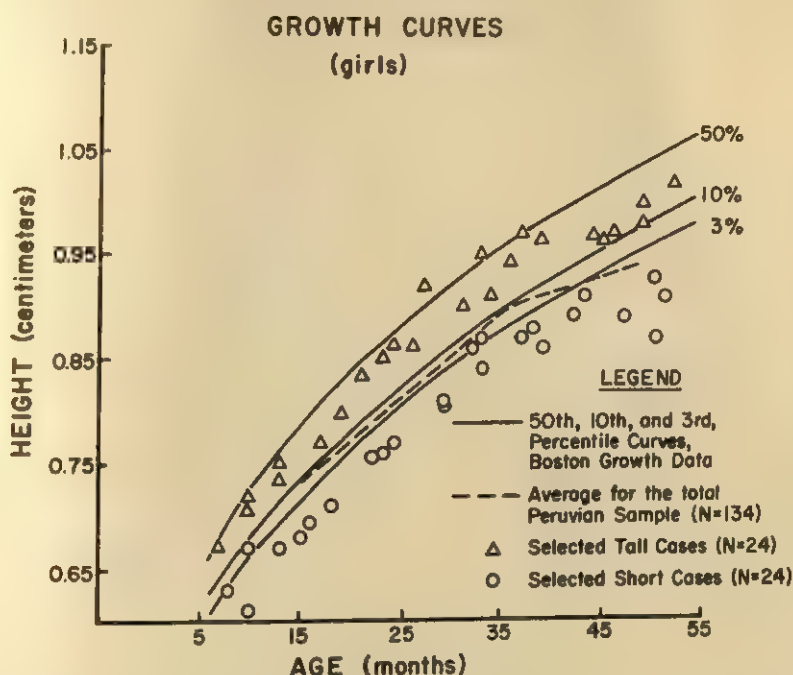
PROCEDURES

The height measurements of all but 24 cases were obtained by one of the investigators. In one institution the measurements were obtained by the health nurse. The children were measured in supine position. Each child was measured twice; in case there was a discrepancy a third measure was obtained and all three were averaged.

The data on the biological and social

* Adopted by the Health Department, Milwaukee, Wisconsin. Anthropometric charts based on original data of H. C. Stuart and H. V. Meredith and prepared for use in Children's Medical Center, Boston.²⁷

Figure 2



variables were obtained by interviewing the children's mothers. The interview used was a modification of the form used by Cravioto et al.⁵ in obtaining comparative information on the social, economic, and educational status of families from two rural height-contrasting groups of children. A section on general medical information, with data on parental height and a brief history of mother's pregnancy and child's birth, were added. The sections on cleanliness and housing conditions were eliminated because not all the mothers were interviewed in their homes.

PRINCIPAL VARIABLES ASSESSED

The main biological and social variables assessed may be listed and defined as follows:

I. PRENATAL VARIABLES

Maternal Height—height in centimeters, obtained by two measurements in a standing position. (All but three mothers were measured.)

Number of Pregnancies—all pregnancies including miscarriages, abortions, and stillbirths. (Target child's ordinal position among the children alive at the time of the interview was also recorded.)

Mother's Age—age at the time of the target child's birth.

II. PARANATAL VARIABLES

Birthweight—mother's report of the child's birthweight. (An attempt was made to obtain the birthweight of the children born in hospitals directly from the records but the hospitals' administration made this search impossible.)

Medical Attention at Childbirth—

mothers' reports regarding whether the target child was born at home with or without medical attention, in the field, medical post, or hospital.

III. SOCIAL VARIABLES

Maternal Education—number of years of schooling reported by mother. (In addition, an attempt was made to determine whether the women were literate or illiterate regardless of their reported years of schooling.)

Family Instability—(1) the number of men with whom the women had lived up to the time of the interview, and (2) the presence or absence of a father figure at the time the interview was carried out.

Family Income—monthly income of family in Peruvian soles. (one sol = .027¢)

Family Size—the number of people living in the house at the time of the interview.

Mother's Years of Residence in Lima—report on the number of years she had been living in Lima.

All interviews were done by one of the investigators (E.P.) and an assistant. Neither examiner knew if the woman interviewed was the mother of a tall or short child. All but three mothers were interviewed; in two of these three cases, the information was obtained from the woman taking care of the home and in the remaining case the father gave the information. An attempt was made to interview all the women in their home; however, many women spent most of their day at work. In these cases the interviews were done at the day care center or at their jobs.

RESULTS

I. PRENATAL VARIABLES

Maternal Height: As would have been expected on the basis of previous reports on the relationship between parents' and children's stature, the mothers of the tall children were significantly taller than the mothers of the short children, by five centimeters. TABLE 2 presents the

Table 2
HEIGHT OF MOTHERS BY AGE, SEX, AND HEIGHT OF CHILDREN
MEANS AND SUMMARY OF ANALYSIS OF VARIANCE
(height in centimeters)

	TALL CHILDREN			SHORT CHILDREN			BOTH		
	M	F	Both	M	F	Both	M	F	Both
YOUNG CHILDREN	151	152	152	146	149	148	149	151	150
OLD CHILDREN	150	152	151	142	146	144	146	149	147
TOTAL	151	152	151	144	148	146	147	150	
Source of Variation	MS	F	p						
Age	.012	5.04	<.05						
Sex	.016	6.66	<.01						
Height	.065	27.12	<.01						
Age x Sex	.001	<1.00	----						
Age x Height	.006	<1.00	----						
Sex x Height	.003	<1.00	----						
Age x Sex x Height	.000	<1.00	----						
Within Cells	.0024								

Table 3
MOTHERS' NUMBER OF PREGNANCIES BY AGE, SEX AND HEIGHT OF CHILDREN
MEANS AND SUMMARY OF ANALYSIS OF VARIANCE

	TALL CHILDREN			SHORT CHILDREN			BOTH		
	M	F	Both	M	F	Both	M	F	Both
YOUNG CHILDREN	3.25	4.08	3.67	4.00	5.08	4.54	3.60	4.58	4.10
OLD CHILDREN	3.75	4.00	3.88	4.66	5.00	4.83	4.20	4.50	4.35
TOTAL	3.50	4.04	3.77	4.33	5.04	4.68	3.91	4.54	
Source of Variation	MS	F	P						
Age	1.55	<1.00	----						
Sex	9.37	1.45	NS						
Height	20.17	3.12	<.10						
Age x Sex	2.66	<1.00	----						
Age x Height	.04	<1.00	----						
Sex x Height	.16	<1.00	----						
Age x Sex x Height	.04	<1.00	----						
Within Cells	6.465								

mean maternal height for all subgroups, and the summary of the analysis of variance in which height, age, and sex of the children were used as the independent variables.* The analysis shows that the difference between the maternal height for the tall (151 cms.) and short (146 cms.) children reached the 0.01 level of significance. Two additional significant findings, difficult to explain, were that the mothers of the females were significantly taller ($p < .01$) than the mothers of the males, and that the mothers of the younger children were taller ($p < .05$) than the mothers of the older children.

It was possible to obtain height measurements on 12 fathers from the tall and 10 from the short group. Both groups of fathers had exactly the same mean, namely 160 centimeters.

Number of Pregnancies: TABLE 3 presents the mean parity for the mothers of the different subgroups of children. On the average, the mothers of the tall children had had fewer pregnancies (3.77) than mothers in the contrasting group (4.68). Although this difference only reached the 0.10 level of significance, it is interesting to note that the direction of the difference was the same for each of the subcomparisons by age and sex. There were no age or sex differences.

Mothers' Age at Childbirth: In the case of this variable there were almost no differences between the two main groups. The mean age was 26.5 years for the mothers of the tall children, and 27.0 years for the mothers of the short group. Likewise, the difference between the age and sex subgroups were not statistically significant.

* Unless otherwise indicated the basic statistical model used has been a three-way analysis of variance, factorial design with equal number of observations per cell.²⁰ If there were three or less observations missing in the total sample, the respective mean of the group was used to cover each of the missing observations. Age, sex, and height of the children were used as the independent variables in the analysis. For the purpose of statistical analysis the children were divided into two age subgroups, young (6-29 months) and old (30-53 months).

II. PARANATAL VARIABLES

Birthweight: The mothers of 32 tall and 24 short children reported the birthweights of their respective children; the remaining mothers said that they did not remember or did not know their children's birthweight. The mean birthweight for the tall and short and for the male and female children are reported in TABLE 4. As expected, the re-

Table 4
CHILDREN'S BIRTHWEIGHT IN GRAMS BY
SEX AND HEIGHT
MEANS AND SUMMARY OF ANALYSIS
OF VARIANCE^a
(weight in grams)

	TALL (N=32)	SHORT (N=23)	BOTH
BOYS (N=25)	3,613	2,757	3,271
GIRLS (N=30)	3,676	3,201	3,470
BOTH	3,643	3,008	
Source of Variation	MS	F	p
Sex	0.866	1.87	NS
Height	5.905	12.80	<.01
Sex x Height	0.479	1.03	NS
Within Cells	0.461		

^a A two-way analysis of variance with unequal observations per cell was used in this case;²⁹ Height and Sex of the children were used as independent variables.

ported birthweight of the tall children (3,643 grams) was much higher than that of the contrasting cases (3,008 grams), and this difference reached the .01 level of significance.

Medical Attention at Birth: According to the mothers' reports, a somewhat higher percentage of the short children (35%) were born without medical attention than was the case for the tall cases (25%); however, this difference was not statistically significant ($p > .10$).

III. SOCIAL VARIABLES

Maternal Education: TABLE 5 presents the reported number of years of schooling for all subgroups. One of the striking observations here is the small number of years of schooling for all cases. Despite this fact, however, mothers of the tall children had significantly more schooling (2.51 years) than the mothers of the short children (1.31 years) ($p < .05$). Moreover, this difference in schooling was consistent in each of the subgroup comparisons by age and sex. In addition, the information on illiteracy also yielded a considerable difference between these groups. Sixty percent of the mothers from the short group were illiterate in contrast to 38% of the tall group, and this difference also was consistent in each of the subgroup comparisons.

Forty mothers of the tall and 43 mothers of the short group provided information on their husbands' years of schooling. Paralleling the data on mothers, the fathers of the tall group had a higher average (4.40 years) than those of the short group (3.61 years); statistically, however, this difference reached only the .10 level of significance.

Family Instability: The number of women who had lived with two or more men differed rather sharply between the two children's height groups. While only 17% of the mothers of the tall children reported two or more "marriages," 42% of the mothers in the contrasting height group reported a similar experience. A χ^2 test showed that this difference reached a respectable level of statistical significance ($p < .01$). No differences were found in the comparisons involving presence or absence of a father figure.

Family Income: In contrast to what

Table 5
MOTHER'S MEAN YEARS OF SCHOOLING BY AGE, SEX AND HEIGHT OF CHILDREN
MEANS AND SUMMARY OF ANALYSIS OF VARIANCE^a

	TALL CHILDREN			SHORT CHILDREN			BOTH		
	M	F	Both	M	F	Both	M	F	Both
YOUNG CHILDREN	2.91	2.83	2.87	1.41	1.08	1.25	2.16	1.95	2.05
OLD CHILDREN	1.50	2.83	2.13	0.83	1.92	1.37	1.16	2.38	1.72
TOTAL	2.20	2.83	2.51	1.12	1.50	1.31	1.66	2.16	
Source of Variation	X ²	df	p						
Age	3.64	3	NS						
Sex	1.20	3	NS						
Height	8.71	3	<.05						
Age x Sex	2.63	3	NS						
Age x Height	6.48	3	<.10						
Sex x Height	.07	3	NS						
Age x Sex x Height	.38	3	NS						

^a The distribution of the mothers' years of schooling was negatively skewed. On this account a three-way nonparametric analysis of variance was used with the same three independent variables included in the other three-way model.²⁴

might have been expected on the basis of previous findings, the reported monthly income for the families of the tall and short children did not differ significantly (Mean Tall=1,467 soles; Mean Short=1,376 soles; $F < 1.00$). Likewise there were no age or sex differences in income between groups.

Size of Family: The average size of family was very similar for the two height contrasting groups. The averages for the tall and short children were 6.66 and 6.70 respectively. Likewise, there were no sex or age differences in family size.

Mothers' Years of Residence in Lima: It was found that the number of years of residence in Lima was quite similar for the mothers of the children in the tall and short groups, 15.83 and 14.39 respectively. Likewise, no appreciable differences were noted between sex and age subgroups.

As one might expect, there was some evidence that four of the five variables

related to children's stature tended to constitute a cluster of interrelated factors: short maternal stature, lower educational level, more pregnancies, and more marriages tended to be associated with one another. On the other hand, birthweight was unrelated to the four variables just mentioned. TABLE 6 presents the rather low, but significant, contingency coefficients among the five variables that differentiated significantly between the tall and short children.

DISCUSSION

The main results of this study of correlates of stature in Lima slum children revealed that mothers of short children, in contrast with mothers of tall children, were significantly shorter (by 5 centimeters), had a reported history of more pregnancies, had significantly less education (1.3 vs. 2.5 years), and had been married significantly more often. In addition, the shorter children had significantly lower reported birth-

Table 6
CONTINGENCY COEFFICIENTS BETWEEN THE VARIABLES THAT PROVED TO BE
SIGNIFICANTLY DIFFERENT BETWEEN THE TWO HEIGHT GROUPS

	MOTHERS' PARITY	MOTHERS' EDUCATION	FAMILY STABILITY	BIRTHWEIGHT
MOTHERS' HEIGHT	0.24 ^a	0.24 ^a	-0.19	0.00
MOTHERS' PARITY	-----	-0.20 ^b	-0.23 ^b	0.00
MOTHERS' EDUCATION	-----	-----	0.00	0.00
FAMILY STABILITY	-----	-----	-----	0.00

^a Significant at the .02 level.

^b Significant at the .05 level.

weights. All of these relationships were quite similar and consistent when examined separately for boys and girls, and for the younger and older children. Moreover, the first four factors mentioned (exclusive of birthweight) tended to be associated with one another.

One of the most obvious first points of comparison evident here is that this cluster of biological and social variables associated with differences in stature closely resembles similar patterns of relationship found in previous studies of malnourished and "normal" children identified mainly on the basis of stature.²³ At the same time, the cluster of variables related to children's stature in this study parallels rather closely the pattern of biological and social factors frequently found to differentiate between so-called "culturally disadvantaged" and middle-class children in developed countries like the U.S.A. and Great Britain.^{3, 10} What makes the results of the present study of particular interest is that maternal stature, education, number of pregnancies, and marital stability were so clearly related to children's stature within a lower socioeconomic or "disadvantaged" sample representing a relatively restricted portion of the total population range.

Let us now return to the central issue of the problems involved in the use of contrasts in stature as a primary index of contrasting nutritional background in children. The present research indicating a marked relationship between children's and mothers' stature suggests that one cannot disregard the possible genetic determinants of height. The contrast between this finding and the previously summarized research of Cravioto et al.⁵ might indicate that the relationship between stature of parents and children varies from one type of "disadvantaged" sample to another. However, the existence of such height relationship in a low socioeconomic group like that of the present research points out that nutritional factors are not necessarily overriding and that genetic effects can confound the significance of using stature as a nutritional index.

In connection with the procedure of using stature specifically in studies of malnutrition and psychological development, the present research underscores significant methodological problems. For all five variables found to be related to stature in the present investigation, there is considerable evidence indicating that these variables are also related to intellectual development, and indeed may

directly or indirectly influence such development. With regard to parental height, for example, as previously indicated, in large-scale studies there tend to be a positive relationship among factors such as stature, intellectual level, and socioeconomic status among adults as well as children. There is even some evidence suggesting possible relationship between parental size and children's psychological test performance within the same socioeconomic level.¹²

A number of further examples of these complicated relationships may be found in the literature. Many studies have shown that children clearly identified as mental retardates of a variety of different types are significantly shorter than equivalent aged children in the general population.^{8, 18, 22} Again, while nutritional deficiencies may be involved here, it is obvious that a number of other factors play a significant role in the production of children who are both mentally retarded and of reduced stature. For example, there is considerable evidence to suggest that in large populations women of markedly reduced stature have a higher probability of being in poor health and nutrition, as well as a higher incidence of prenatal complications and premature births.^{25, 26} Moreover, in women of low socioeconomic status increased parity is associated with a heightened probability of premature births, of neonatal mortality,¹⁹ and of congenital malformations of the nervous system.²⁰ When severe enough, these various complications of pregnancy and birth have been shown repeatedly to be associated with impaired intellectual development, quite independently of problems of postnatal malnutrition.^{17, 21} When one considers that the short children in the present study had shorter mothers, with

greater parity, and were of lower birth-weight as compared with the tall children, the difficulty of relating possible intellectual deficiencies of the short children to postnatal malnutrition is made particularly clear.

Let us turn next to a consideration of the socio-environmental factors represented by maternal education and family instability in the present study. As previously indicated, there is a large body of evidence indicating a substantial positive relationship between socioeconomic level and children's intellectual status. Parental education, which is one of the main indices of socioeconomic level, has shown a particularly consistent relationship to children's intellectual development in early and later childhood, especially when the educational range represented is relatively broad, and to developmental quotients in the first few years of life.^{1, 11, 15} In recent years research has been directed increasingly at the identification of those patterns of interaction between mothers and young children which play a significant role in fostering early learning and intellectual growth, and which may be quite different in families with different social and educational backgrounds.^{2, 14} In regard to the present study, even though the educational differences between the mothers of the tall and short children were small and at the lower end of the educational scale (2.5 vs. 1.3 years of schooling, on the average), it is reasonable to assume that these mothers may well have employed different child-rearing practices, not only in regard to nutrition and health but also in the amount and kinds of psychological stimulation and opportunities for learning which they provided.

Marital or family instability is also

found more often in the lower socioeconomic levels,¹³ and thus may be viewed as part of the cluster of factors which have been found to be associated with lower intellectual levels in children. A related recent finding provides some additional information of interest on this matter. Werner et al.²⁸ reported that the intellectual development of children born under conditions of prenatal stress was significantly better if their home had been rated as "stable" (i.e. having less emotional stress) rather than "unstable."

In summary, the results of the present study are interpreted as confirming our concern that while differences in slum children's stature may reflect differences in nutritional background, they also reflect differences in a number of other biological and social factors associated with, or capable of influencing, intellectual development in children. Consequently, in most retrospective studies it would be virtually impossible to specify whether behavioral or intellectual differences between tall and short children are primarily a function of nutritional factors, or of some of the other factors associated with stature, or of some combination of these variables. Hence, in studies of undernutrition and psychological development it would be very unwise to use differences in stature as the principal index of previous nutritional history. Obviously, more direct measures of nutritional status and nutritional history would be considerably more desirable, but even this information is not always readily obtainable.

The problem of designing studies to assess the influence of malnutrition on psychological development in children involves a good many methodological difficulties, only a few of which have

been discussed briefly in the present paper. While an adequate treatment of these difficulties in research design would require extended discussion which is beyond the scope of this report, it seems clear that retrospective studies are not likely to be very fruitful, particularly if stature differences constitute the main measure of nutritional background. It is the writers' contention that a more productive approach is likely to be found in prospective or experimental studies designed to permit an assessment of the interactions among known variations in nutritional status, dietary intake, parent-child relationships, amount and kind of stimulation for learning in the home, etc., as these factors jointly influence psychological development.

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USE OF DAY TREATMENT CENTER CONCEPTS WITH STATE HOSPITAL INPATIENTS

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Would the therapies and team approach used in day treatment centers have any effect as an adjunct for the treatment of chronic inpatients in traditional mental institutions? In this study of 204 inpatients, the experimental group with which the day treatment concepts were used performed significantly better on an objective measure of intelligence than did the control group.

The comprehensive community mental health facility has become a major emphasis in the treatment of the mentally ill today. The focused treatment modality is the day treatment center (DTC) which attempts to prevent the creation of the institutionalized patient of the traditional mental health facility. In approaching the problem of the chronic, institutionalized schizophrenic in a typical mental health institution, it seems reasonable to question why this day treatment concept could not be used with a chronic inpatient population.

Studies by Meltyoff and Blumenthal,⁴ Healy, Seny, Althushul, and Levinson,² and Peck⁶ have shown that the psychiatric day hospital concept, with its inclusion of the team approach to mental

illness, might be a useful alternative to the concept of total hospitalization for many psychotic patients. At Rusk State Hospital, lacking any comprehensive community mental health programs in the broad geographic area served by the hospital, it was conceived that a DTC could be a useful *adjunct* for the treatment of inpatients in this traditional mental institution.

The DTC was established for the hospital community alone. It was set in a modern, spacious building which included facilities for occupational, recreational, and educational therapy incorporated into a comprehensive program and daily routine that also included social therapy and group psychotherapy. The DTC concepts were applied in a

school-type setting to further reduce the stigma of "mental illness" and to promote the concept of "mental health." Since most patients have been in a school situation before, they could more readily identify this atmosphere as a learning situation than as a form of institutional treatment. The patients left their "dormitories" each morning to ride a bus to the DTC, which was some distance from the hospital.

Three hypotheses were formulated to test for the effectiveness of the program: (1) patients involved in the DTC would perform significantly higher on a paper and pencil performance test than would patients not involved in the DTC; (2) patients involved in the DTC would have a higher rate of discharge than would patients not involved in the DTC; and (3) patients involved in the DTC would have a lower rate of recidivism than would patients not involved in the DTC.

METHOD

The Ss considered for this research were 650 male and female patients from the adult psychiatric units of Rusk State Hospital. All patients were included in the research population except those who were severely brain damaged, grossly retarded, or nonfunctioning geriatrics (even some of these were included by special request from the unit teams). Each patient was tested to establish a minimum Beta IQ score of 60 as a criterion for inclusion in the research population. The population was then divided randomly into two groups—one experimental, the other control.

Because of the exclusions mentioned, the number of Ss was reduced to 300. Because of discharges before a three-month length of stay in the DTC program could be completed, the number

of Ss included in the final form of the research was further reduced to 204 (102 in each group). The experimental group consisted of 32% males, the control group of 42% males. 91% of the experimental group were Caucasian, 81% of the control group were Caucasian. Using the χ^2 technique, no significant differences were found for either sexual or racial distributions.

The patients were matched on three variables and then randomly assigned to one of the two groups matched according to (1) age, (2) pretest scores on the Beta, and (3) length of hospitalization. TABLE 1 shows the results of the matching variables. All differences found were chance differences beyond the .02 level of confidence.

Each patient in the experimental group was scheduled into the complete DTC program. Using the Beta, the staff of the DTC placed each patient into one of six groups of approximately 17 patients each. Group placement was determined by the quality of the patient's reality orientation and/or integration of thought processes. Each patient group rotated through all five areas each day—occupational therapy, educational therapy, recreational therapy, social therapy, and psychotherapy. The program began at 8:30 a.m. and was completed at 3:00 p.m. on a five-day week basis. The patients returned to their wards each day at 11:30 for the noon meal. The patients in the control group were involved in all programs and activities allowed in the hospital except the DTC.

The five areas incorporated a wide variety of reintegrative therapies. The occupational therapy section was divided into three sections of manual arts, graphic arts, and home arts. Each was designed to reduce the staff-patient ratio

Table I
MATCHING VARIABLES BETWEEN EXPERIMENTAL AND CONTROL GROUPS

MATCHING VARIABLES	\bar{X}	SD	t	df	p
PRETEST SCORES					
Experimental Group	88.03	11.31	.17	202	.02
Control Group	88.31	11.96			
AGE					
Experimental Group	42.34 ^a	1.37	1.82	202	.02
Control Group	40.41 ^a	11.74			
LENGTH OF STAY IN HOSPITAL					
Experimental Group	5.63 ^a	6.65 ^b	.16	202	.02
Control Group	5.78 ^a	6.88 ^b			

^a Indicates years.

^b Characteristic of a positively skewed curve.

to a minimal level to encourage individualized participation in creative endeavors.

The educational therapy section was divided into two sections of general basic education and a more advanced typing course. The emphasis of the former was on the stimulation of basic educational skills which might have been lost or forgotten during the course of the patient's illness. The emphasis of the advanced typing course was on the productive capacity of the patient rather than participation. The typing class presented an opportunity to gain occupational skills which might be used to the patient's advantage at a later time.

The recreational area included dancing, yard games, bowling, hikes, and calisthenics. This program was designed to give the patient much needed exercise and the opportunity to experience give-and-take relationship on a team basis.

The section that was designated social therapy was designed to advance social

reintegration in a warm, comfortable physical surrounding. The patient was encouraged to invite friends and relatives to join him in the relaxed atmosphere of the "social room." Many modern social conveniences were at the patient's disposal in this area with the exception of a television set, which was felt to be a detriment to the social interaction and free flow of conversation deemed necessary for the reestablishment of social skills.

The psychotherapy section combined most of the more formalized approaches to group therapy as well as some innovative group work on the part of the individual therapists. These include such approaches as psychodrama, social group work techniques, remotivation, traditional group therapy, educational and psychological films, current events and discussion groups.

At the end of approximately three months, each S in both groups was retested using the Beta. The mean

posttest Beta IQ scores for the experimental and control group were compared by Fisher's *t*. The two groups were also compared for percentage of patients discharged and furloughed, and for percentage of patients returned to the hospital after an interval of another seven months. There was no alteration of medication or discharge procedures for either group.

RESULTS

Fisher's *t* was used to compare posttest Beta IQ scores for the experimental and control groups. The scores were found to be significantly different beyond the .02 level of confidence (TABLE 2).

A further analysis of the data indicated that the experimental group performed significantly better ($p=.02$) from pretest to posttest on the Beta, whereas the control group performed significantly worse ($p=.02$) from pretest to posttest on the Beta.

The percentages of patients leaving the hospital on furloughs and discharges and the percentages of patients returning to the hospital were compared for both groups for the 10 months from the beginning of the program to seven months after it ended. The percentage of patients leaving the hospital from the experimental group was 54.8% and the return percentage was 16%.

The percentage of patients leaving the hospital from the control group was 34.3% and the return percentage was 25.7%. χ^2 showed a significant difference, beyond the .01 level of confidence, for the number of patients discharged or furloughed from the hospital from the two groups. The differences found between the two groups for the percentages of patients returned to the hospital were chance differences below the .05 level.

DISCUSSION AND CONCLUSION

The research gives supportive evidence to the effectiveness of the DTC concept, with educational procedures, for a traditional mental health institution population. Although the instrument (Beta) used to measure intellectual functioning in this research population was standardized on a male population only, a study by Patrick and Overall⁵ showed that the Beta was an adequate measure for females as well.

Beta IQ scores were used in this study to indicate changes in intellectual functioning of the subjects. However, studies by Coppinger, Bortner, and Saucer,¹ Johnson,⁸ and Santostefano⁷ suggest that performance scores are also related to personality integration, i.e. that poor performance test scores are a reflection of poor personality integration. If that

Table 2
POSTTEST BETA IQ SCORES OF EXPERIMENTAL AND CONTROL GROUPS

	\bar{X} Posttest Beta IQ Scores	SD	<i>t</i>	df	p
EXPERIMENTAL GROUP	96.07	12.65	11.18	101	.02
CONTROL GROUP	83.55	11.18			

be the case, then the DTC program increased personality integration as well as increasing intellectual productivity.

Another indicator of the effectiveness of the DTC was the higher percentage of discharges and furloughs for the experimental group (54.8%) as compared to the 34.3% for the control group. The low 16% return for the experimental group also indicates that the DTC showed marked progress in curtailing the rate of recidivism to the traditional mental health facility.

The significant drop in Beta IQ scores for the control group was felt to reflect a loosening of their personality integration. This seems to be the result of a lack of a comprehensive, therapeutic program utilizing the team approach to the mentally ill and, perhaps, a result of the effects of institutionalizing patients. A note of interest was the fact that even though the patients in the control group showed a decline in personality integration, 34.3% of these patients were discharged or furloughed

from the hospital. Their higher rate of return to the hospital seemed to be an indication that the progress of their illness had not really been halted or reversed.

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FOLLOWUP EVALUATION OF FAMILY CRISIS THERAPY

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Six-month followup evaluations of 150 family crisis therapy cases and 150 hospital treatment cases demonstrate that those treated as outpatients do as well as the hospital cases. Social functioning is maintained equally in both groups. Patients are less likely to be rehospitalized if admission was avoided initially.

Crisis therapy has evolved from increased attention to the ego and its decompensation in the face of external stress. The techniques focus on coping style and ego support rather than on insight into unconscious conflict. The goal of crisis therapy is integration and recompensation.

The brief therapies have also evolved in a changing political arena, which declares that health services are a right of all citizens rather than the privilege of a few. To some, the brief therapies represent an expedient distribution of services, so that everyone gets a little rather than a few getting a lot. To other professionals, crisis therapy is seen in

a more positive light as an opportunity for mastery rather than regression.

Crisis therapy has received more attention at a time when the role of the mental hospital is being questioned. Repeatedly it is found that institutional settings encourage disability rather than overcoming it. To remove a patient from his home and job to a distant hospital adds problems to the existing disability. Hospitalizing one member of a family gives credence to the disease model and suggests that the problem is entirely within the patient's biology or psyche.

The focus on crisis therapy and community mental health has been accom-

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panied by many claims of efficacy and success, but few have been based on followup studies. The federal legislation encouraging community mental health centers has given great impetus to program development but there is a dearth of evaluative research. Outcome studies used to focus on personality change; brief therapy is not designed to seek change in long-term behavioral patterns. Instead it attends to functioning, adaptation, symptom reduction and the avoidance of hospitalization. In this study of family crisis therapy (FCT), the design of the project included systematic evaluation from its inception. This paper will report the results of a comparison of FCT and hospital treatment for two groups, each consisting of 150 patients randomly selected from a population which would ordinarily be treated by immediate admission to a mental hospital. Six-month followup data are reported for both groups. Eighteen-month data are presently being collected and analyzed.

PROCEDURES

From 1965 to 1968 the Family Treatment Unit at Colorado Psychiatric Hospital (a University of Colorado psychiatric treatment center) selected and treated a random sample of those patients ordinarily immediately admitted to the hospital. These patients all lived in a family within an hour's travel from the hospital. An equal-sized sample of control patients was drawn from the same population. The control patients were all hospitalized. Baseline measures of social adaptation, functioning, crisis management, and other clinical schedules were obtained from FCT and hospital cases. Treatment of the FCT cases was carried on by a full-time clinical team

from the Family Treatment Unit. Control cases were admitted to the hospital and treated by the inpatient service professional staff.

The techniques of FCT are reported in a book recently published by this group.² Treatment for the FCT cases consisted of an average of 4.2 office visits, 1.3 home visits, 5.4 telephone calls, and 1.2 collateral contacts with social agencies. The treatment was carried on over a mean period of 24.2 days from admission to termination. All 150 FCT cases were treated without admission to the hospital. Despite the fact that this group consisted of a sample of patients ordinarily hospitalized immediately (including acutely disturbed schizophrenics, suicidal depressive and other dramatic behavioral disturbances), it was possible to effect recompensation and remission using the treatment described above.

Patients admitted to the hospital were treated with individual and group psychotherapy, milieu therapy, pharmacotherapy, and the varied approaches of a modern psychiatric hospital. The average length of stay for hospital cases was 28.6 days.

Followup studies were done six months after discharge from treatment and annually thereafter. The evaluations were done by professional social workers employed on a part-time basis. These clinicians had no other connection with the project. The baseline scales and measures were repeated in addition to a clinical interview in the family home of each patient.

FINDINGS

Although the randomness of sample selection procedures gives confidence that the groups are comparable, further

Table 1
COMPARISON OF 149 FCT AND 150 HOSPITAL PATIENTS

AREA OF COMPARISON	CHI ²	DEGREES FREEDOM
Sex	.61	1
Age	6.74	7
Marital Status	8.14	4
Race	2.03	3
Religion	8.14	4
Social Class	7.54	4
Geographic Residence	0	3
Brought to Hospital By	6.29	5
Voluntariness of Admission	1.00	1
Day of Week Admitted	7.73	6
Time of Day Admitted	14.33 ^a	3
Number of Previous Psychiatric Hospitalizations	.09	1
Suicidal Attempt or Ideation	7.95	6
Diagnosis	3.79	5
Number of Previous Nonhospital Psychiatric Contacts	10.87	7
Presence of Spouse in Household	1.61	2
Presence of I.P.'s Father in Household	.07	2
Presence of I.P.'s Mother in Household	3.08	2
Presence of Father-in-Law in Household	5.06	2
Presence of Mother-in-Law in Household	3.94	2
Presence of Grandparents in Household	3.50	2
Number of Marriages of I.P.	5.14	4
Number of Marriages of I.P.'s Spouse	3.59	4
Number of Marriages of I.P.'s Father	2.11	4
Number of Marriages of I.P.'s Mother	1.16	4

^a $p < .01$.

examination confirms this. FCT and hospital cases are compared on 15 characteristics and 10 additional features of family composition (see TABLE 1). It will be apparent that the groups are similar in terms of the patients (age, sex, race, marital status, social class, religion), the area of residence, the types of families, previous mental hospital admissions, and diagnosis. Indeed, the only significant difference is due to the time of day admitted, a factor due to the increased number of hospital cases admitted during the night hours. Since the FCT and hospital groups are indistinguishable by χ^2 , the groups comparisons are valid undertakings.

One measure of outcome is the fact that all FCT cases were treated without admission to a mental hospital. Was hospitalization truly avoided or merely postponed? It is no problem to keep patients out of a hospital; one merely has to close the door. For this reason careful records were kept of subsequent hospital histories for both groups. TABLE 2 presents these data for both groups during the six months immediately following treatment. It should be emphasized that the hospitalizations listed are readmissions for the control group and initial hospitalization for the FCT cases. The data makes it clear that treating an acute regressive episode by admission to

Table 2
HOSPITALIZATION OF 150 FCT AND 150 HOSPITAL CASES

	Cumulative No. of Patients Hospitalized		Cumulative No. of Hospital Days		Percent of Potential Hospital Days		Percent of Sample Not Hospitalized	
	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.
Acute Treatment Period	None	150	None	4,284	None	100%	100%	None
1st Posttreatment Month	5	28	70	417	1.6%	9.3%	96.7%	81.3%
2nd Month	10	29	178	834	2.0	9.3	93.3	80.7
3rd Month	12	33	307	1,191	2.3	8.8	92.0	78.0
4th Month	14	36	433	1,602	2.4	8.9	90.7	76.0
5th Month	18	38	521	2,013	2.3	8.9	88.0	74.7
6th Month	19 ^a	41 ^a	609	2,335	2.3	8.6	87.3	70.7

^a $\chi^2=10.06$.

$p<.001$.

a mental hospital increases the probability of readmission. 29% of the hospital cases are readmitted within six months, while only 13% of the FCT cases are hospitalized during that period. When it is necessary to hospitalize from either group, the length of stay is also affected by the previous treatment. If previous treatment was hospital admission, the re-hospitalization is nearly three times as long for the group. More than 1,700 additional man-days were spent out-of-commission in a mental hospital by the group previously hospitalized.

Another measure of comparison centers on the adjustment of the patient before and after treatment. Since the goal of FCT (as well as that of hospitalization) is to effect recompensation and readjustment to the usual environment and usual role performance, instruments were chosen to focus on this area. The Social Adjustment Inventory (SAI) taps information under the headings of Social and Family Relations, Social Productivity, Self-Management and Antisocial Behavior.¹ These four scores are combined to make a total

SAI score. On this measure, lower scores indicate "better" social adjustment. This scale was administered at baseline, and at three and six months after treatment for both FCT and hospital cases. In some instances three-month measures were not obtained, but the six-month measures are available for 90% of both groups. Group mean scores are listed in TABLE 3. Comparisons between FCT and hospital cases at baseline, three months, and six months were tested by significance by a matrix of t tests. No differences between groups were found on any of the subtests or total scores at baseline, three months, or six months. The measures of difference from baseline to three months and six months are significant in Family and Social Relations, Social Productivity, Self-Management, and Total Scores for the FCT group. The hospital group shows significant improvement from baseline to three and six months in Social Productivity. Self-Management improves from baseline to six months for the hospital cases, and the Total Score for this group improves significantly at three months, but not at six. Although the differences between

Table 3
SOCIAL ADJUSTMENT INVENTORY GROUP MEAN SCORES

	Social & Family Relations		Social Productivity		Self-Management		Antisocial Behavior		Totals	
	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.
Baseline	3.14	3.15	2.89	2.79	2.43	2.47	2.01	2.01	10.46	10.44
3 months	2.89	2.92	2.34	2.44	2.23	2.28	1.98	1.88	9.43	9.54
6 months	2.73	2.91	2.13	2.18	2.20	2.27	1.97	1.89	9.03	9.67
N			Significant Differences							
	FCT	Hosp.			t	P				
Base	142	150	FCT Base vs. 3 mo.		1.98	<.05	Social & Family Relations			
3 mo.	112	114	FCT Base vs. 6 mo.		3.46	<.001	"			
6 mo.	132	135	FCT Base vs. 3 mo.		3.51	<.001	Social Productivity			
			FCT Base vs. 6 mo.		4.97	<.001	"			
			Hosp. Base vs. 3 mo.		2.29	<.05	"			
			Hosp. Base vs. 6 mo.		4.29	<.001	"			
			FCT Base vs. 3 mo.		1.98	<.05	Self-Management			
			FCT Base vs. 6 mo.		2.31	<.05	"			
			Hosp. Base vs. 6 mo.		1.98	<.05	"			
			FCT Base vs. 3 mo.		3.47	<.001	Totals			
			FCT Base vs. 6 mo.		4.88	<.001	"			
			Hosp. Base vs. 3 mo.		2.73	<.01	"			

FCT and hospital groups do not reach significance, the trend is in the direction of better role performance by the FCT patients. It is of interest that so little change takes place in Antisocial Behavior, a fact probably due to the chronicity of these patterns. Neither short-term FCT or hospitalization changes long-term maladaptive behavior.

Another instrument was developed to measure role performance at work, school, or household, as well as health and presence or absence of psychiatric symptoms. This Personal Functioning Scale (PFS) was administered at baseline and at the six months evaluation. As with the SAI, lower scores indicate "healthier" functioning. The findings (TABLE 4) are similar to those seen with the SAI. There is improvement from baseline to six months which is highly

significant for both FCT and hospital cases. The groups do not differ from each other either at baseline or at six months. The major change is in the area of Psychiatric Symptoms.

Symptoms usually associated with psychiatric illness are not necessarily deleterious to family life. These symptoms are found in significant proportions of people who are not hospitalized. They are labeled eccentricity unless the symptomatic individual has been hospitalized and then become labeled "mental illness." The amount of time lost from work, school, or homemaking does affect the family, however. The breadwinner out of commission in a mental hospital, or the homemaker similarly treated, does affect the family and community in substantial fashion. TABLE 5 summarizes days lost from functioning

Table 4
PERSONAL FUNCTIONING SCALE GROUP MEANS

	Functioning		Health		Psychiatric Symptoms		Totals	
	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.	FCT	Hosp.
Baseline	2.49	2.56	2.31	2.23	3.04	3.08	7.80	7.87
6 months	2.05	2.08	2.00	1.85	2.44	2.42	6.45	6.35
N		Significant Differences						
Base	FCT	Hosp.			t	p		
6 mo.	132	150	FCT Base vs. 6 mo.		3.98	<.001	Functioning	
	141	131	Hosp. Base vs. 6 mo.		5.12	<.001	"	
			FCT Base vs. 6 mo.		3.71	<.001	Health	
			Hosp. Base vs. 6 mo.		5.04	<.001	"	
			FCT Base vs. 6 mo.		8.16	<.001	Psychiatric Symptoms	
			Hosp. Base vs. 6 mo.		8.71	<.001	"	
			FCT Base vs. 6 mo.		7.09	<.001	Totals	
			Hosp. Base vs. 6 mo.		8.62	<.001	"	

at the usual role assignment during treatment. It also reports days after treatment before resumption of usual functioning. Data is available on 90% or more of both samples. The median number of days is probably a more accurate representation since the mean could be skewed by a few disproportional

values. The hospital cases are "out of commission" for 23 days as compared with five for the FCT cases. The difference represents nearly two weeks per patient. Similarly, the median case lost no time before resumption of usual role functioning when treated by FCT, but lost another three days following termination if treated by hospitalization.

Table 5
DAYS LOST FROM FUNCTIONING
DURING TREATMENT

	FCT (N=140)	Hosp. (N=138)
MEAN	10.0	32.4
MEDIAN	5	23
S.D.	13.8	28.1

DAYS LOST AFTER TERMINATION
BEFORE RETURN TO FUNCTIONING

	FCT (N=139)	Hosp. (N=126)
MEAN	26.0	47.8
MEDIAN	0	3
S.D.	50.4	70.0

DISCUSSION

It is apparent that patients treated by FCT instead of admission to a mental hospital are functioning as well six months later, and are less likely to have spent part of that six months in a mental hospital. The average FCT patient will have gained two weeks of role functioning. Cost estimates, presented in another report,³ also demonstrate that FCT is far less expensive (one-sixth or less) than the cost of hospital treatment. Throughout the nation, discussions of health care services focus on the dra-

matic increases in cost. These are mostly attributed to the expense of hospital treatment rather than to outpatient costs. Increased cost is true for mental hospitals as well as general medical hospitals. Mental health professionals cannot ignore cost in organizing mental health services for large populations.

The deleterious effects of unnecessary hospitalization are well documented. Any hospital admission involves regression and disruption of individual and family life. Admission to a mental hospital still carries significant social stigma and may influence subsequent employment, admission to college, the ability to obtain a driver's license, or other real-life factors. Unnecessary hospitalization is also an unnecessary expense to someone. It is incumbent on all of us to seek alternatives to hospitalization and to avoid unnecessary admissions. The findings of this project, with its systematic efforts to do careful sampling and followup evaluation with minimal bias, are that most patients admitted to a mental hospital can be treated by FCT if they live in a family and are reasonably close to a treatment center. Of the total population admitted to Colorado Psychiatric Hospital for 1967, 53% met these criteria.

Why family? The choice of conjoint family crisis therapy rather than individual crisis therapy focuses on two factors: (1) family or interactional tensions are often the precipitant of psychotic regression in a susceptible patient; (2) the family is a source of strength, support, and aid, as well as of problems. The family has always been

the first arena of help for crises. To remove a patient from the family (by hospitalization) removes him from a potential source of psychological support. The goal of FCT is not to blame the family but to help the entire group resolve current difficulties. The patient who lives alone presents a more difficult problem. He can often be treated by individual crisis therapy, but it is doubtful that all cases in this series could have been managed without a family.

Do these findings suggest that we ought to close all the mental hospitals? That is not the interpretation or suggestion of this report. It is easier to avoid hospitalization for those who live in a family, but not all patients do. A certain proportion of patients seen in mental health centers will require specialized treatment available only in a hospital. A certain population of individuals accustomed to using the mental hospital to solve problems will make it difficult to avoid hospitalization. Nevertheless, it is apparent that most patients from an acute psychiatric hospital can be treated with FCT with results equal to those achieved by hospitalization.

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ALCOHOLISM: METHODOLOGICAL CONSIDERATIONS IN THE STUDY OF FAMILY ILLNESS

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Information obtained from alcoholic subjects about the prevalence of psychopathology in their first-degree relatives is compared with the prevalence obtained in a personal examination of these same relatives. The number of positives for psychopathology increased by 175% when the relatives were interviewed.

Information obtained from patients about the presence of psychiatric disorder in other family members is frequently used by investigators of psychiatric illness. This information is particularly sought in genetic and family history studies of psychiatric disorder. Many therapists use the information obtained from the patient about relatives in attempting to provide post-hospital care—living arrangements, continued use of therapeutic drugs, a supportive environment. It seems worthwhile then to be able to assess the reliability of information given by the patient about the pres-

ence of any type of psychiatric disorder in his relatives. Also, it is useful to know if the socioeconomic class of the patient will affect the reliability of the report and to know if patients give more reliable information about parents, sibs, or children.

Little data are available on this subject. Guze et al.⁴ have made one of the few studies in the area of reliability of information. Guze compared what relatives said about the drinking history of subjects to the material that had been obtained in interviews with the subjects. He reported 26% disagreement, with

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80% of the disagreement involving a positive response by the subject and a negative response about the subject when the relative was asked the same question. Guze's study was the only one we could discover where an attempt was made to compare information obtained from subjects with information obtained from relatives. The psychological abstracts from 1940 to the present were examined in an attempt to find relevant articles. None could be found.

This present paper is an evaluation of the reliability of interview information concerning psychiatric symptoms of patients' family members.

METHOD

The data were collected by administering a systematic interview to 147 alcoholic subjects and 395 of their first-degree relatives. Fifty-nine of the subjects were drawn from Renard Hospital. Renard is a private psychiatric hospital which is part of the Washington University Medical School complex. The criterion for selection in the Renard sample was admission to Renard Hospital with a problem involving alcohol abuse. The rest of the subjects were drawn from Malcolm Bliss Mental Health Center. Malcolm Bliss is a state hospital serving the St. Louis metropolitan area as a public, acute psychiatric treatment facility. At Malcolm Bliss the criterion for selection as part of the study was admission to the alcoholic unit of that hospital. In addition, at both hospitals, at least one first-degree relative for each subject—child, sibling, or parent—had to be available for interview.

The attempt was made to interview all living first-degree relatives within a 50-mile radius of St. Louis. 85% of the first-degree relatives in the St. Louis

area were interviewed. The patients refused to allow contact to be made with 29 relatives; an additional 20 relatives could not be located. Four other relatives refused to be interviewed and the attending physician refused to allow 7 relatives to be contacted.

The interviews were administered by either a social worker, psychiatric resident, or senior medical student. All the interviewers were trained in the use of the interview. The data collected in the interviews were evaluated with the aid of four fully trained psychiatrists involved in the study. The probands and the relatives were told that all first-degree relatives would be or had been contacted as part of the research project. They therefore had no apparent reason to falsify or leave out information.

Part of the interview given to the subjects and to their relatives centered on family history in an attempt to delineate psychiatric symptoms and mental hospitalization in the first-degree relatives. For each first-degree family member, the presence of alcohol abuse, psychiatric problems, and police problems was questioned.

The information about alcohol abuse was obtained by asking if the relative drank. If he did drink, how much, and did he have any problems (police, domestic, job, etc.) in relation to his drinking.

For psychiatric problems it was asked whether the relative had had any psychiatric hospitalization, suicide attempts, had ever seen a psychiatrist or other doctor for nerves. It was asked whether the relative had ever taken medicine for nerves, if he was nervous, jumpy, moody, bizarre, etc. Specific psychiatric symptoms whenever available were noted. In the event of a psychiatric hospitalization,

information concerning the nature of the state of the pre- and post-hospital functioning of the relative was sought.

Information about police problems was obtained by asking if the relative had ever been arrested, if he had been arrested, for what, how many times, with how many convictions and jail sentences.

A history of any school problems was sought in the same fashion. It was asked if the relative had school problems. If so, what kind, and with what consequences.

The remainder of each interview was spent in the attempt to make an accurate psychiatric diagnosis of the interviewee. The interview took from 45 to 180 minutes to complete. The average was approximately one hour.

All pertinent and available medical and social records for probands and their relatives were examined.

Differences were tested for statistical significance by χ^2 with Yates correction. Differences at the 0.05 level of statistical confidence were considered significant, i.e., the probability was one in 20 that the difference resulted from chance.

DIAGNOSTIC CRITERIA

■ Alcoholism was defined after Jellinek⁶ and the World Health Organization²: drinking in such a way as to interfere with one's way of living as evidenced by any one of the following—job, police, domestic, or health problems related to drinking.

■ Affective disorder was defined as given by Cassidy et al.¹: The patient had to manifest the symptom criteria for affective disorder without preexisting alcoholism, sociopathy, anxiety neurosis, hysteria, or schizophrenia.

■ The symptom criteria for sociopathy

were essentially those given by Guze^{3, 4}: a history of police problems in a person with early onset of excessive fighting, delinquency, job troubles, sexual promiscuity, a period of wanderlust, or being a runaway. Any two of these six established the diagnosis.

■ The criteria for schizophrenia were from Langfeldt et al.⁷ and Stevens and Astrup¹¹; anxiety neurosis from Wheeler et al.¹²; obsessional neurosis from Pollitt⁹; and hysteria from Perley and Guze.⁸

■ Drug addiction was taken as drug use involving withdrawal symptoms, hospitalization for abuse or withdrawal, or prolonged use of drugs.

■ Homosexuality referred to recurrent or persistent homosexual acts.

■ Organic brain syndrome referred to confusion of time, place, etc., not related to any other psychiatric disorder.

Alcohol abuse, regardless of other symptomatology, was the criterion for the probands included in this study. Reference made in this paper to the diagnosis of relatives, however, refers only to the primary disorder.

In addition to the above-mentioned diagnostic criteria, a report by a proband of a relative's psychiatric hospitalization was considered sufficient to make a positive diagnosis of psychiatric disorder for that relative, even if no symptoms were known.

In some cases a positive or negative for psychiatric disorder in a relative was based upon more than just the interviews with the subject and the relative. This occurred in two types of situations. In one, family members indicated problems about a relative which the relative denied in his interview and which the proband had not mentioned. This occurred only twice. In the other

situation, the relative denied what the proband had said about psychiatric disorder in that relative. When either of these situations occurred, the weight of all evidence was evaluated before a positive was assigned. In general, no positive was assigned unless proof of hospitalization was obtained, or unless two first-degree relatives indicated that the problem existed.

RESULTS

Of the 395 first-degree relatives interviewed, 132 were assigned a positive diagnosis of psychiatric disorder. If only the probands' interviews had been used as information, 50 positives would have been assigned. Over 63% of the relatives with psychiatric disorder would have been missed if the family history had been obtained only from the proband. These 63% may be considered false negatives. Two false positives were recorded, i.e. the proband gave suffi-

cient information for a positive to be assigned to a relative but after the relatives' interviews a negative was assigned.

The probability of proband interview alone being as equally powerful a tool as proband plus relative interview in determining the prevalence of psychiatric illness in relatives was less than one in 10,000 ($p < 0.0001$).

Part A of TABLE 1 breaks down the relatives by place of hospitalization of proband. The χ^2 for both hospitals exceeds the .0001 level of confidence. When the hospitals are compared to see if there is a difference in the reliability of subjects in either hospital, the difference is not significant. This is noteworthy because, since one of the hospitals was private and the other public, they draw from markedly different socioeconomic groups. Also noteworthy, Renard and Bliss patients had an almost identical percentage of psychiatrically ill relatives.

TABLE 1, part B, breaks down the

Table 1
MISSED PSYCHIATRIC DISORDER IN RELATIVES

A	NUMBER OF RELATIVES INTERVIEWED	NUMBER OF POSITIVES	NUMBER OF FALSE POSITIVES	NUMBER OF FALSE NEGATIVES
PLACE OF HOSPITALIZATION OF PROBAND				
Renard	113	38	1	24 ($\chi^2=13.04$, $p.<.001$)
Malcolm Bliss	282	94	1	60 ($\chi^2=34.99$, $p.<.0001$)
Total	395	132	2	84 ($\chi^2=48.00$, $p.<.0001$)
B	NUMBER OF RELATIVES INTERVIEWED	NUMBER OF POSITIVES	NUMBER OF FALSE POSITIVES	NUMBER OF FALSE NEGATIVES
SEX OF PROBAND				
Males	263	78	1	50 ($\chi^2=28.1695$, $p.<.0001$)
Females	132	54	1	34 ($\chi^2=20.28$, $p.<.0001$)

Table 2
MISSED PSYCHIATRIC DISORDER—BY TYPE OF RELATIVE

RELATIONSHIP TO PROBAND	NUMBER INTERVIEWED	NUMBER OF POSITIVES	NUMBER OF FALSE NEGATIVES	NUMBER OF FALSE POSITIVES	CHI ²
Parents	104	35	25	2	$X^2=13.7419<.0005$
Children	69	23	15	0	$X^2=8.1543<.01$
Siblings	222	72	44	0	$X^2=24.9879<.0001$

relatives according to the sex of the proband. There is no difference in the reliability of information from either males or females. Forty-one percent of the relatives of female probands were found to have or have had psychiatric illness as against only 30% of the male probands' relatives. This indicates a trend, but it is not statistically significant ($X^2=2.43$, $p<0.15$). This same trend has been noted by other studies.^{10, 13}

TABLE 2 breaks down the relatives seen according to their relation to the subject. The false negatives remain around 60%. It is statistically significant for parents ($p<0.0005$), sibs ($p<0.0001$), and children ($p<0.01$). When the cells are compared to see if there is any difference in the reliability of the information about different relative groups, no significant difference is noted. This finding is striking, for one might expect people to know less about the psychiatric problems of their parents, more about the problems of their sibs, and the most about the problems of their children. There is also no statistically significant difference in the prevalence of psychiatric illness in the three groups.

TABLE 3 breaks down the psychiatric illness into diagnostic groups, with the number of false positives for each category. Where the groups are large enough

for statistical comparisons, as in affective disorder and alcoholism, there is no significant difference between the groups as to the rate of occurrence of false positives. When the other diagnostic categories are added together to present a group large enough for statistical comparison, no statistically significant difference is obtained.

Table 3
MISSED PSYCHIATRIC DISORDER—BY TYPE OF DISORDER

DIAGNOSIS	NUMBER OF DIAGNOSES MADE	NUMBER OF FALSE NEGATIVES
Affective	55	38
Alcoholism	48	26
Sociopathy	9	4
Anxiety Neurosis	5	4
Obsessive Neurosis	6	5
Hysteria	4	4
Schizophrenia	2	1
Undiagnosed	3	2

DISCUSSION

As can be seen from the data presented, a great deal of pathology will be missed if only the proband's information

is used. For the total sample, about 63% of psychiatric disorder was missed. In other words, 84 diagnoses would have been missed on the basis of subject interviews. This represents approximately 22% of all relatives interviewed. The same rate of pathology is missed regardless of the sex of the proband. Men, therefore, are apparently as reliable informants as women. The same ratio of pathology is missed regardless of the relation of the relative to the subject. No particular relative, it seems, is therefore more likely to present the most reliable information.

It can safely be assumed that the two hospital sources of subjects, Renard and Malcolm Bliss, draw from markedly different socioeconomic classes. Despite this, there is no difference in the reliability of the informants from either hospital. Apparently then, economic background has no influence upon the reliability of the information that is presented.

The high amount of missed pathology would indicate that genetic studies which did not use personal family interviews would miss fairly substantial amounts of striking pathology. This present study used fairly conservative standards and still uncovered a high prevalence of psychopathology. It would appear then that unless adequate controls had been used, many family studies would be invalidated. Furthermore, unless very large amounts of pathology are found, or unless a very large sample has been used, statistical significance will be very hard to obtain for those seeking to indicate some genetic factor. The amount of missed pathology in the un interviewed relatives would rule against the positive outcome of the family study of the genetic base of psychiatric disorder.

For example, assume that a study had

a sample population of 100 with a control of 100. If the control group has a true incidence of 12 and the sample a true incidence of 30, the χ^2 will equal 9.765 ($p < 0.01$). If we use as our incidence rate the one-third, according to this study, that would be obtained from relatives about the two groups, the respective rates are only 4 and 10 with a χ^2 equal to only 1.91, which is not significant. In this example, to obtain statistically significant figures from these two groups on the basis of another's information, we must have a sample with a prevalence of 42 out of 100 to obtain 13 so that the χ^2 will be significant above the .05 level. This demonstrates the necessity of using personal interviews in genetic studies.

These findings would also seem to indicate that those who are relying upon stable family members to assist in post-hospital rehabilitation had best be sure of the psychiatric status of these relatives. The personal interview and evaluation seems to be the only way that this can be done with any degree of certainty. Alcoholics and other psychiatrically ill persons present enormous emotional and practical problems to those with whom they live, and could easily exacerbate minor psychiatric problems or upset persons with unstable personalities. Careful evaluations of the state of the mental health of important relatives would therefore seem to be in order in plans in followup care. Only major and striking pathology was noted in this study and large amounts went unreported by the subjects. Probably even as many, or more, diagnoses of unstable and neurotic personalities would be missed in these relatives.

One could assume that considerable amounts of psychopathology will be

missed in family histories from any source. Guze's study would certainly lend support to this generalization. In the absence of more extensive use of control populations it must remain an unfounded, though highly likely generalization.

An interesting finding of this study was that no difference occurred in the prevalence of psychiatric disorder for various relative groups. The relative groups were compared by relation to the subject, the subject's place of hospitalization, and the sex of the subject. Only in the case of sex was a trend discovered, which then only reached the 0.15 level of significance, with women having a slightly higher rate of affected relatives.

One may apparently expect to find as much familial psychiatric illness in patients representing markedly different socioeconomic classes. One may also find disorder apparently spread evenly through the generation levels of a patient's family. In other words, the prevalence of psychiatric disorder is the same for parents, siblings, and children. Only in the case of female alcoholic patients may one expect a slightly different rate of psychiatric disorder in the relatives.

It is striking that in this study only two false positives were noted. This indicates that one may place high reliability in those cases of psychiatric disorder reported by the subject in his relatives. The alcoholic subjects seem to err on the side of ignorance and caution rather than on the side of vindictiveness. One might have conjectured that they would try to create the impression that they are no worse than others, but evidently when one hears from an alcoholic that pathology is to be found in another relative, one can be almost sure that it does exist.

The overall disagreement rate of

around 22% and the small amount of false positives corresponds well with the figures obtained by Guze et al.³ Perhaps the high false-negative rate found in our study is the rough figure of the amount of pathology in others that one can expect to miss. If so, the importance of controls and the importance of the personal interview becomes crucial when the relative or persons involved have direct bearing upon the successful outcome of patient treatment.

There are a number of possible explanations for the extent of pathology unreported by the alcoholic subjects. The two that appear most likely are: One, the longer time and more exhaustive interview used with the relative in question than with the alcoholic, and two, the changed perception of the alcoholic.

Explanation number one seems to be that with the increased length of time, greater personal contact, and more exhaustive inventory of the relative, more pathology would inevitably be turned up by the interview. However, the large proportion of rather marked disorders that are missed by interviewing only the index case is still unusual. This is even more striking if one remembers that all of the interviewed relatives live in the same metropolitan area as the subjects.

Explanation number two suggests that another factor is at work. This factor is the tendency of the alcoholic to consider problems only if they affect him in a detrimental and personal way. If this is the case, the psychiatric disorders reported by the subjects were only disorders that interfered with the subjects' functioning. The unreported disorders did not interfere. To discover, then, whether one can generalize the findings of this study to other populations, in-

cluding normal or even other psychiatrically ill, other studies are incumbent.

An important finding of this research was the large amount of psychiatric disorder in the first-degree relatives. Using the above-mentioned conservative standards to judge psychiatric disorder, 33% of contacted relatives were positive or had been positive for psychiatric disorder. Even if one assumes that all of the uncontacted first-degree relatives were negative, the figure still stands at 29%. However, for two of these relatives, the subjects indicated they had received hospitalization for psychiatric disorders. The rate of 33% obtained is significantly higher than the lifetime prevalence rate of 19.11% as reported by Helgason.⁵

It seems that the alcoholic family presents an unusually rich family background and breeding ground for psychopathology. Whether this is due to environmental or to genetic influence is of some importance for future preventive measures, but in light of current knowledge, a moot point. Perhaps later stages of this research or a future study will answer this question. The extent of the psychiatric disorder obtained would indicate that for the present some attention must be given to these families rather routinely as likely multiproblem families.

Along with the high prevalence, one notes a striking preponderance of alcoholism and affective disorder in the first-degree relatives interviewed. These two disorders accounted for 103 of the 132 positives, or 77% of the total diagnoses. Twenty-six percent of all relatives had one of these two disorders. The rate for affective disorder was 14%, and for alcoholism 12%. The high rates for these two disorders lend credence to Cassidy and others^{1, 13} who have indicated that

alcoholism and affective disorder appear to be related in some fashion. The high rate for these two disorders is the rate only for the primary disorder; the depression or alcoholism noted is not secondary to another problem. It seems clear, then, that in this sample of hospitalized alcoholics, affective disorder and alcoholism clearly predominate in the family members. Sociopathy accounts for a diagnosis in only nine of the family members, or 2%. These figures are different from those that have been noted by other investigators of the first-degree relations of alcoholics. Guze et al.⁸ in their study of criminals found that 7% of the relatives had a diagnosis of sociopathy and only 4% of the relatives had a diagnosis of affective disorder. This would indicate that hospitalized alcoholics are quite different by family psychopathology from samples of alcoholics drawn from prisons.

Two relatives received a diagnosis of schizophrenia, a prevalence of .5%. This low figure is similar to the findings of other investigators of the relatives of alcoholics.

SUMMARY

This paper has compared the reliability of information from alcoholic subjects about the prevalence of psychiatric disorder in their first-degree relatives with the information obtained in a personal interview with these relatives. It was discovered that 63% of psychiatrically ill relatives were missed using only the family history given by the subjects. The information obtained was incorrect about the relatives in 22% of the cases. These were almost all false negatives. Only two false positives were noted. When the data were examined it was found that there was no difference in

reliability by sex of subject, by the socioeconomic status of the subject, or by nature of the relative.

Subjects from hospitals representing different socioeconomic classes had no difference in prevalence of disorder in their relatives. The prevalence of disorder was the same in parents, sibs, and children. Women, however, had a larger number of psychiatrically ill relatives—41% compared to 30% for men—but this difference did not reach statistical significance.

Approximately 85% of available relatives were interviewed. Of those interviewed, 34% could be classified positive for psychiatric disorder. Two-thirds of those diagnosed were classified as having either affective disorder or as having alcoholism. This finding supports those who maintain that these two disorders are in some way related.

The primary finding of this study is that when reliable information about the psychiatric disorder in a subject's family is needed, the only way it may be obtained is through personal interview with the relatives.

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FIVE YEARS LATER: A FOLLOWUP STUDY OF COMPREHENSIVE VOCATIONALLY ORIENTED PSYCHOTHERAPY

Milton F. Shore, Ph.D. and Joseph L. Massimo, Ed.D.

This is the second in a continuing series of followup studies of adolescent delinquent boys successfully treated in an experimental program five years ago. Few legal difficulties, stable employment, and personal growth were shown in those treated. On the other hand, three of the untreated youth were in adult correctional institutions, employment was irregular, personal rewards few. Contact with usual rehabilitative agents of society seemed unable to reverse the deterioration in the untreated group.

Detailed and repeated followup studies over long periods offer unique opportunities to investigate the subtle changes that occur over time in treated and untreated groups. Such studies can answer a most important question. Does successful therapeutic intervention at one stage in the developmental process of an individual aid him in his ability to cope with later developmental issues? That is, is the success of the intervention only a temporary phenomenon delaying an inevitable breakdown later on?

It is for that reason that the delinquent adolescents in a successful, comprehensive, vocationally oriented treatment program have been followed since the end of treatment five years ago. The details of the program, which combined remedial education, job placement, and psychotherapy administered by a single practitioner over a 10-month period, have been reported in this JOURNAL¹ and in another publication.² The program differed from many other programs for adolescent delinquents in a number of ways. It was initiated at a

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crisis point—within 24 hours after the boy had left school (he had either dropped out or was expelled). The three aspects of the program were combined in flexible fashion with few restrictions as to time, place, or activity (the youth was often seen on the job or other places in the community for periods ranging from a few minutes to many hours over many days where necessary). The program was also kept independent of schools and other community agencies. Motility and action were stressed, with many techniques used to make the learning relevant to everyday activities, to relate psychotherapeutic insights to daily functioning, and to aid the youth in developing those skills necessary to perform adequately on the job.

Evaluation of the program took place along three dimensions—overt behavior, achievement in academic areas, and changes in personality functioning. Descriptively, marked changes were noted at the end of the 10-month treatment period in job history and legal status in the treated group as compared to the untreated group. Highly significant improvement was also found in the treated group in the areas of Reading, Vocabulary, Arithmetic Fundamentals, and Arithmetic Problems. (These were skills that were not able to be developed by the usual remedial services within the school system.) Changes in ego functioning were very marked in the treated group, with significant improvement in self-image and control of aggression. The control group, on the other hand, not only showed little change but revealed marked deterioration as time went on and as social expectations and the need to function more maturely increased.

A study of these three areas of functioning two years following treatment

was also reported in this JOURNAL.⁸ There was continued progress in the treated group even though treatment was terminated. This progress, however, was at a slower pace than during the treatment period. The untreated group continued its deterioration in all areas.

Now a five-year followup of the experimental and control boys has been completed. An effort was made to get a detailed history of jobs, marital status, training, and legal status since the last followup. The data cover the period of June 1966 to July 1968. In order to avoid contamination, the data were collected by a person other than the therapist, a person the boys did not know. As in the previous followup, the therapist had no contacts with the boys other than casual conversations when he saw them in the community. The results are shown in TABLE 1. It is clear that the treated group has continued to do well while the untreated group has continued to deteriorate in every way.

Of the 10 who were treated, only two are unemployed. These two also have a high incidence of legal difficulty.

Since 1966 four more treated boys have obtained some formal schooling (added to those on the previous followup, a total of seven of the 10 treated have obtained some formal schooling either during or after treatment). Significantly, however, the training did not come through the usual educational channels of high school or college, but through special vocational training programs (mechanics programs, night schools, specialty schools, etc.). The legal involvements of those in the experimental group who had decided on these programs were minimal.

One major difference from the previous followup in the experimental group

Table 1
JOB HISTORY AND LEGAL STATUS ON FIVE-YEAR FOLLOWUP

BOY NO. ^a	NO. OF JOBS SINCE JUNE 1966	PRESENT POSITION	PAY	FORMAL SCHOOLING SINCE JUNE 1966	LEGAL STATUS AND MISCELLANEOUS SINCE JUNE 1966
Experimental 1	0	Tester with an electronics firm	\$2.10	Electronics course offered by company	No arrests, married, 1 child.
2	1	Auto body foreman	\$4.20	None	No arrests, 1 dis- orderly conduct charge heard and informally dealt with. Married, no children. Seen by family service for marital counseling.
3	0	U.S. Army— career soldier	--	U.S. Army personnel clerk school	No arrests, single.
4	1	Works for city as rubbish collector	\$2.30	None	No arrests, married, 2 children.
5	2	Photography studio assistant	\$2.10 day \$1.65 night	Graduated from high school in 1966. Attending photog- raphy school part- time.	No arrests, married, 1 child. Holds sec- ond job in gas station at night.
6	3	Unemployed	---	None	Single, 1 arrest on assault & battery after release from state hospital (2- year suspended sentence). Walk-in at psychiatric clinic.
7	1	Unemployed	--	None	Two arrests on traffic violations. Single.
8	0	Draftsman	\$3.75	None	No arrests, married, 1 child.
9	0	Mechanic	\$3.50	General Motors transmission school	One arrest for driv- ing under the in- fluence. Married.
10	1	Mechanic	\$3.85	None	No arrests, married, 1 child.

^a In order that comparisons could be made on each individual, each boy's number is the same as in the other studies reported.

Table 1 (continued)
JOB HISTORY AND LEGAL STATUS ON FIVE-YEAR FOLLOWUP

BOY NO. ^a	NO. OF JOBS SINCE JUNE 1966	PRESENT POSITION	PAY	FORMAL SCHOOLING SINCE JUNE 1966	LEGAL STATUS AND MISCELLANEOUS SINCE JUNE 1966
Control 1	3	Makes donuts for donut shop	\$1.60	None	Separated from wife, 1 child. Two arrests—car theft (2 years suspended sentence), drunk & disorderly (pending). On probation.
2	3	Unemployed	--	None	One arrest for car theft. Spent 6 months in house of correction. Single.
3	5+	Garbage truck driver for city	\$2.35	None	One arrest on possession of marijuana (suspended sentence). Married, no children.
4	2	Mailman for firm	\$2.10	None	No arrests, married, 1 child.
5	4	Unemployed (part-time short-order cook)	--	None	Completed 2-year sentence for grand larceny. On probation. Single.
6	0	Assembly line	\$1.80	None	Two arrests—traffic violations (license suspended), drunk & disorderly. On probation. Married but separated.
7	Whereabouts unknown. Family gone. Believed to be in California.				
8	3	Mechanic	\$3.00	General Motors transmission school	No arrests, married, no children.
9	--	--	--	--	Serving 5-10 years in state penitentiary for manslaughter. Single.
10	3	Gas station attendant	\$1.65	None	Three arrests—drunk & disorderly, suspicion of narcotics, assault. Trial pending.

^a In order that comparisons could be made on each individual, each boy's number is the same as in the other studies reported.

was that the number of jobs held by the treated boys has decreased significantly in this two-year period compared to the first two or three years following treatment. It appears that the boys in this group have settled down to a career choice and no longer feel a need to change jobs frequently to attain advancement (their salaries have continued to rise). Is this "settling" not the normal developmental task of the post-adolescent period?

On the other hand, three of the control group have been incarcerated in adult criminal institutions on major charges (one more than on the previous followup). Only two have had no arrests (as compared to seven in the treated group). The number of jobs held by the untreated boys over this period is significantly higher than in the treated group, suggesting marked job dissatisfaction (their salaries remained low). Only one boy in the control group has obtained some formal schooling since June 1966 (he had taken a correspondence course previously). In marital status, two in the control group who were married have separated from their wives.

The finding of a high correlation between legal status and job history, although significant, is not a simple one. It is clear that unemployment is perfectly correlated with arrests in both groups. However, the types of job and the levels of attainment and advancement seem very important. The person in the control group who was a skilled worker had no arrests. Others in the

control group who, perhaps because of limited skills, were gainfully employed over long periods but in unskilled jobs showed involvement in many legal difficulties. Therefore, employment by itself does not seem to serve as a deterrent to crime if this employment has no meaning, no status, and no opportunities for learning and personal growth.

The most distressing finding thus far, however, is the outcome of those who have had contact with the agents of society that are set up to rehabilitate the deviant—the state hospital and the prisons. All who had had contact with these agencies were unemployed, and often again in trouble with the law. If the correlation between unemployment and legal involvement continues (as seems likely), the prognosis for this group is indeed poor. Such a finding certainly adds additional support to the need for finding ways of helping these individuals, ways which differ from the current, often outmoded institutional framework.

A 10-year followup on these boys is planned.

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CLINICAL

FACTORS AFFECTING THE OUTCOME OF CHILD PSYCHIATRIC CONSULTATIONS

P. O. Davidson, Ph.D. and A. R. Schrag, M.D.

A followup study of children seen for psychiatric consultation established several variables as significant determinants of whether the recommendations made during the consultations would or would not be carried out. Many of these factors can be manipulated by the psychiatrist in order to ensure that his consultations are more effective.

Child psychiatric consultations are sometimes problematic, for their effectiveness depends to a large part on carrying out the recommendations of the consultation yet the psychiatrist often has little responsibility for implementing these recommendations.

Most medical specialists receive a majority of their consultations from other medical colleagues, and the treatments recommended in the consultation are either initiated by the specialist himself or sent back to the referring doctor with considerable assurance that they will

be followed. Many child psychiatrists, however, receive a majority of their consultations from nonmedical referrals (schools, welfare agencies, courts, directly from the family, etc.), and once the recommendations for handling the child have been sent back to the referral source the psychiatrist all too frequently has little influence (or even knowledge) on whether his recommendations are carried out or not. The effectiveness of a child psychiatric consultation is consequently a function of two variables: first, the sagacity of the recommenda-

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tion, and secondly, its implementation.

The present study was designed to evaluate those factors affecting the implementation of child psychiatric recommendations. Specifically, this study was concerned with psychiatric consultations made in a child guidance clinic where a majority of the cases were family or social agency referrals and not medical referrals.

METHOD

Cases which had been seen at a child guidance clinic for psychiatric consultation only were selected from one calendar year (1962) for a detailed followup evaluation by a research team that had no previous contact with these cases. Whenever possible, the team saw both parents, the child, and the original referring source.

Followup information was obtained on a total of 780 children. The children ranged in age from 1 to 18, with a majority in the age range 6 to 12 years. The intellectual rating of these children showed an essentially normal distribution around a mean of 90. Approximately one-half of the cases were from urban homes (cities or towns) and one-half were from rural homes (villages and farms).

Results reported in an earlier study¹ had indicated that one of the most important factors determining the effectiveness of psychiatric consultations was whether the psychiatric recommendations had been carried out or not. The present study was concerned with isolating those factors which were relevant to the execution of the psychiatric recommendations.

Followup information was obtained on 70 variables which might affect the fulfillment of recommendations, and χ^2

values were computed between these 70 variables and the variable of whether the recommendations were carried out or not.

RESULTS AND DISCUSSION

Over 52% of the referrals made in 1962 did not carry out the recommendations made to them at the initial psychiatric consultation. This is an alarmingly high percentage and indicates the extreme importance for followup of child psychiatric consultations and the need to ascertain the factors contributing to this result.

TABLE 1 shows the χ^2 values for some of the important variables relevant to carrying out of recommendations. The psychiatric recommendations were carried out significantly more often if both parents accompanied the child to the consultation and significantly less often if the mother was absent. The recommendations were more apt to be carried out if the child was brought to the guidance clinic and less apt to be if the psychiatrist went to see the child at a public health office or a school. Recommendations made for children under the age of 9 were far more apt to be followed than for children aged 14 and over. Referrals received from welfare agencies and ministers were carried out much more often than referrals made from schools.

The attitudes of the parents toward their child's problem proved to be one of the most significant factors in determining whether the recommendations were carried out or not. If the parents' view of the problem agreed with that of the psychiatrist, they were far more apt to accept the psychiatric recommendation than if they disagreed or saw a related problem.

Table 1
ANALYSIS OF VARIABLES AFFECTING THE CARRYING OUT OF
PSYCHIATRIC RECOMMENDATIONS

VARIABLE	CHI ²	P	SUMMARY OF EFFECT
Place of family residence	2.87	NS	No rural/urban differences
Where child was seen	24.47	.02	Better if seen at guidance clinic
Which parents accompanied	23.93	.05	Better if both parents
Number of times seen	18.74	NS	No effect
Age of child	50.82	.01	Younger the better
Sex of child	5.03	NS	No effect
Psychiatrist seeing child	33.81	.01	More experienced the better
Nature of presenting problem	24.73	.05	Better with clearly emotional problems
Intelligence of child	11.44	NS	No effect
Referral source	18.87	.02	Better if from social agencies
Length of wait for appointment	9.26	NS	No effect
Wait on day of appointment	20.20	.01	Better if less than half hour
Initial attitude of parents	62.44	.001	Better if agreed with psychiatrist
Change in parents' attitude	43.14	.001	Better if now agree with psychiatrist
Child's reaction to consultation	12.28	NS	No effect
Child teased about consultation	7.13	NS	No effect
Parents talked to others about child's problem	38.61	.01	Better if parents had talked to others first

For example, Donald M., a 9-year-old boy, had been referred by the school because of "underachievement." The teacher indicated a considerable amount of interpersonal friction between Donald and his classmates, Donald frequently playing the bully. In the class Donald was constantly seeking attention and approval from the teacher to the extent that he often disrupted class lessons. Donald was the oldest in a family of five, having four younger sisters. The oldest girl was an extremely bright girl, in the same class as Donald, who apparently routinely reported Donald's misbehavior to the parents, with the result that Donald received erratic but severe punishment from his parents. It was obvious that Donald was being treated far differently in the family than his four sisters—more punishment, less attention and affection. When the parents attended the clinic, however, they were under the impression that the purpose of the clinic was to "straighten out the school." If

Donald wasn't learning, it was the school's fault, and problems with the teacher were obviously her fault since Donald was "never a problem at home." The parents refused to accept any suggestions from the psychiatrist for modified home management because, they insisted, the problem was not in the home. At the time of followup, Donald had failed a grade and was involved in a juvenile delinquency court action.

Those parents who, at the time of the followup, had come to agree with the psychiatrist's evaluation of the problem, were far more inclined to carry out the psychiatric recommendations than those who continued to disagree with the psychiatric evaluation. This finding underlines the importance to child psychiatrists of identifying the parents' attitude toward their child's problem and trying to change that attitude if it is incorrect. The psychiatrist who makes recommendations to a family without first taking the time to do this is probably

wasting his time, according to the findings from this study!

A rather extreme and unusual example of this occurred in one of the small isolated communities where a 12-year-old girl, Marion, was referred by the school for "daydreaming." Initial consultation and subsequent evaluation confirmed a diagnosis of uncontrolled petit mal epilepsy which apparently had not been detected or even suspected previously. However, in discussion with the parents, it was discovered that they were opposed to medical doctors. The child had been seen a few times for other reasons by the family chiropractor, and the family had only come to the guidance clinic under considerable pressure from the school. At the suggestion of epilepsy, the parents became quite disturbed and hostile, obviously emotionally equating this word to "insane." They refused to consider medication since there was nothing "mental" about their little girl. Since a public health nurse was available in the area, an attempt was made through her contacts with both Marion and her family to modify their attitude toward epilepsy. It was almost a year later before the parents considered, reluctantly, permitting treatment for Marion. The subsequent improvement in her school and personal adjustment was remarkable to the parents on followup, at which time they were enthusiastically and scrupulously ensuring that Marion adhered to her medication schedule.

In view of the above cautions, it was interesting to note that the number of times a child was seen initially was not a significant factor in ensuring that recommendations were carried out. This finding needs to be interpreted cautiously, however, since in many instances

those children who were seen several times were cases where the parents would not accept the initial recommendations made because they disagreed with the psychiatrist's evaluation and refused to accept the recommendations in spite of repeated interviews.

The child's reactions to consultation were not nearly as important as the parents' in determining the effectiveness of the consultation. There was no significant relationship between carrying out recommendations and the reactions of child to the consultation before, during, or after.

Another finding indicating something about the importance of parents' attitudes was that those parents who had discussed their child's problem with others (school counselors, family doctor, etc.) were inclined to follow the psychiatric recommendations more often than those parents who talked to no one else about their child's problem.

A surprising finding, but one which merits attention by child psychiatrists with very busy schedules (what other kinds are there?), was that families who had to wait more than an hour to see the psychiatrist on the appointment day were far less disposed to follow his recommendations than families who waited one-half hour or less! On the other hand, the length of time that parents had to wait between the time of request and day of appointment did not affect the frequency of carrying out recommendations. The average waiting time for children in this study was slightly over one month. About 10% were seen within a week, while 8% had to wait more than three months. Perhaps if there is a critical point of waiting it was not reached for a majority of this group.

There were no rural-urban, intelligence, or sex differences relating to likelihood of recommendations being carried out.

Finally, and not surprisingly, it was found that the senior psychiatrist with many years of experience was more successful in getting his recommendations carried out (perhaps they were also more realistic recommendations) than were junior psychiatrists, and the psychiatric residents were least successful of all.

With the possible exception of the last result, most of the variables found to be significant in the present study were variables which psychiatrists can take into account and perhaps modify in increasing the efficacy of their child psychiatric consultations.

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PARENTAL LOSS AND SOME CHARACTERISTICS OF THE EARLY MARRIAGE RELATIONSHIP

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People who had experienced the final disruption of a previous fundamental relationship through the death of a parent were studied in the first few years of their marriage. The results contribute to the understanding not only of pathological issues in marriage such as the inability to maintain trust or resolve anger but also of nonpathological issues such as interpersonal closeness.

The literature on the later effects of losing a parent is abundant. A history of parental loss has been associated with psychoneurosis,⁶ suicide,¹¹ alcoholism and narcotic drug addiction,⁵ schizophrenia,⁷ depressive illness,⁹ anxiety reactions,² sociopathic character and criminal behavior,⁴ poor employment record,⁸ and failure in the Peace Corps.¹² Many of these studies deal with loss from separation, divorce, or death without distinguishing among them. Looking specifically at the effects of bereavement

at a young age, Barry and Lindemann¹ summarized their clinical material as follows: "If married, they were so afraid of losing their family that their spouses and their children felt safe in making unreasonable demands of the patient, who then reacted with outward submissiveness and inward resentment and depression." Others¹⁰ have described "the inability to let anyone else care," "shallow and meaningless relationships," and "the fear of letting anyone else get to know them." A minority view

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holds that while parental divorce and separation are significant, parental death has not been demonstrated to be a factor in psychopathology regardless of parent lost or the age that loss occurred.³

By and large, one is left with the impression that a history of parental death will probably be associated with severe trouble in the early years of marriage, a time when issues of trust, separation, autonomy, and sexuality are encountered with great intensity. We were therefore surprised when studying a group of 30 couples selected because they were exceptionally close, had relative freedom with intimacy and communication, and enjoyed each other to an unusually full extent, to find that the incidence of parental death prior to marriage in these couples was 40%, twice that of the entire volunteer pool from which they had been drawn. It was this curious finding which led us to the present search for the variety of marriage outcomes associated with a death in the family of origin and some of the factors involved.

METHOD

A test sample of 90 couples with a history of parental death prior to marriage and a control sample of 30 couples with no history of parental loss from any source were drawn from a population of 1,200 couples who were paid volunteers in a study of early marriage. These subjects were American born, in their first marriage, married for two and a half years or less, between 18 and 25 for the wife and 20 to 27 for the husband, living in the Washington, D. C. area, and included both white and Negro couples.

The subjects were seen for a total of approximately seven hours on three separate occasions. A battery of informa-

tion-gathering and personality tests were administered, and joint and individual interviews were held. Ratings were made by the interviewer and an observer. For more intensive studies, certain couples were chosen for group interviews and role-playing improvisations. Among the parameters to which particular attention was paid were interpersonal closeness, the handling of anger, and sexuality.

MARRIAGE TYPES

In our population of couples with loss, four marriage types or syndromes seem to stand out:

1. The first syndrome to be described is the "closeness, late loss syndrome." The median age of loss for this group was 17, with all but three experiencing the loss during adolescence. Of our loss sample, 13.3% exhibited this syndrome, characterized by the following:

The marriage relationship was clearly central to these couples. There was a great degree of closeness, depth, or intimacy, feelings of openness of communication, feelings of gratitude for the spouse, and a feeling of family reconstitution. They see their having found each other as a stroke of good fortune.

They tend to see themselves as a largely self-contained unit and judge their actions according to the satisfactions they derive rather than according to a notion of normalcy or convention. They are not invested in conspicuously flouting convention; rather they seem not especially concerned with it.

Couples in this group used words such as these to describe their relationship: unique, sensitive, fun, mutual, honest, complete, responsible, unconventional, ultimate.

There was no overall suppression of anger. However, there was a marked

commitment, often explicit, to limit the duration of anger or argument. None of the couples reported arguments lasting overnight; most said that their arguments lasted less than half an hour and often only a few minutes. Arguments were frequently terminated by one spouse responding to a display of sadness from the other and noting that the issue "was not worth it." The issue was, however, generally brought up again a few hours or days later, either to explore it seriously or to dispose of it in a playful way.

Affect regarding loss of a parent was in general easily available in the interview and the relationship with the parent was recalled as a particularly good one.

Mrs. M was talking volubly about the happiness of her relationship with her husband when suddenly she came almost to tears when questioned about the death of her father at age 13. She recalled how much she had missed her father and she thought that she had learned because of this loss not to take too seriously any defects or difficulties but to bear in mind what really counted was "not having the relationship die completely."

The interviewers felt the spouses as individuals to be likeable and self-examining. The husbands, compared to other husbands, seemed remarkably at ease with tenderness. Sexual experiences for these couples were satisfying and without major problems.

2. The second syndrome is characterized by the loss of wife's parent in mid-adolescence and the wife having a marked inability to enjoy sexual relations in an otherwise close marriage. 18.5% of couples with a loss of wife's parent after age 12 ($N=27$) fit this pattern, with about half having lost a father and half a mother. The median age at loss was 16.

In these marriages, the husband tends

to be caretaking at home and steady at work. Although he is disturbed by his wife's unresponsiveness, he is seen as being forbearing and patient by her. Both wish the situation to improve but feel helpless to have it do so.

Mr. and Mrs. B expressed a feeling of gratitude for having found one another, felt they had grown enormously during the five months of their marriage, and were extremely pleased with their independence and their high acceptability by friends and employers. After a week or two of mildly enjoyable sexual relations, wife ceased having any sensations whatsoever and looked at sexual relations as a task to be given in to, distasteful and to be feared, although she had no reasons why. Her mother had died when she was 16, approximately four years prior to her marriage. In conversation she revealed the fantasy that now she was in the position of being a mother, identified with her own mother and felt fearful for her own life. In addition she talked about the seductive manner of her father before and especially after her mother's death, and her extreme guilt in responding to this in fantasy, although not in actuality. She felt that since her mother was not present it was particularly disloyal to have felt the way she did, and these feelings were again aroused during the sexual play prior to intercourse. She returned for three followup interviews and in the last interview, which was held together with her husband, she said that the situation had modified itself dramatically and that for the first time since her honeymoon she was beginning to enjoy sexual relations.

3. The third syndrome is comprised of couples in which the husband's father has died and the husband's struggle with dependency and identity are prominent in the marriage relationship. 15% of couples with a history of loss of husband's father ($N=40$) made up this syndrome, and the median age of loss was 8.

The following is a composite profile of the husband in these marriages: He is a pseudo-optimist: "I never worry about anything. This worries my wife, that bothers me." He uses jokes and teasing to avoid confrontation but is able

to break out of this and support his wife solidly if she is in trouble. He is heavily involved with female pursuits, such as housekeeping and cooking and is hypercritical of his wife in these regards. There is less sexual activity than desired by wife. He is capable of sustaining warmth and is appreciative when he receives it. He acknowledges his wish to be "spoiled" but is ambivalent about being "too thoughtful." Anger is more easily triggered, and he both sulks more profoundly and erupts more noisily than the couples described above. Arguments may result in silence for a day or two and there is more likely to be physical violence such as hitting or throwing things, or the threat of it such as reckless driving. Following the argument, solidarity is increased more by the knowledge that the relationship has withstood the crisis than by understanding the issues. The same issue in the same form is likely to repeat itself although diminish in frequency. In the interview, affect does not change when talking about his father, although he may talk about his mother with enthusiasm. He is sometimes flamboyant in his presentation, sometimes mildly depressed, but almost always cagey. He feels things are better than ever before in his life and he doesn't want to rock the boat.

4. In the fourth syndrome, characterized by early loss and chronic conflict, there is difficulty in developing and almost total failure in sustaining intimacy. 11% of our loss sample comprise this syndrome. The median age at loss was 7, about half the losses being mothers and half fathers.

These marriages are seen as being shaky and uncertain. Sexual relations are intermittantly enjoyed and often avoided. Husband insists on one or more

nights out a week to "protect his independence" and spends them with old unmarried friends, usually male.

Anger is prolonged for several days or weeks and marked by separations of several hours or more. Anger is terminated by fatigue, diversion, or capitulation but almost never by agreement. Other people are often brought into the argument, particularly parents of relatives, but sometimes friends as well. After termination of arguments, the marriage partners feel relieved but suspicious. The spouse with the loss usually feels deprived, restless, and trapped. The spouse without the loss usually feels guilty, bewildered, and then trapped as well.

These marriages are obviously in profound difficulty. The following words were used by one of these couples to describe their relationship: Husband: love, hate, war, peace, satisfaction. Wife: rocky, wild, understanding, contempt, loyalty. Rage and ambivalence are clearly illustrated. In this particular couple there was a struggle towards a better relationship, but in others the marriage was conceded to be on the verge of ending.

CLINICAL ISSUES

The following examples are not presented as marriage syndromes but as a sampling of issues encountered in couples with a history of loss.

Interference with the development of the marriage relationship, and the confusion of affect which comes from having both to mourn one close relationship and to celebrate another at the same time, was strikingly apparent in the following marriage which took place when loss was acute.

Two weeks before her wedding, Mrs. A's

father was hospitalized and died. Four months into the marriage she finds herself increasingly preoccupied with thoughts of separation, abandonment, and her own annihilation. She now cries frequently and has begun to be overly concerned with any activity that might involve risk, such as driving a car or even walking across the street. She would like to reach out to her husband but feels unable to do so. Most important, she misses not having any really romantic feelings about him which she vaguely remembers having had some time in the past. In her marriage she often feels she is an innocent victim of a fast-talking and unfamiliar man.

In couples with loss, fears of dying or losing the spouse were frequently explicit and in several instances took the form of asking the spouse at the time of marriage to promise that he or she would never die or leave. These feelings typically began around the time of agreement to marry, or a few months after marriage together with a growing feeling of dependency. These fears, although sometimes recurrent, were generally circumscribed. The following unusual couple has made fear of death and separation, defenses against these eventualities, and attempts to master old losses, a central focus of their marriage.

Mr. O's father died when O was 14, after a year's illness. Husband's only remark about the loss is that it allowed him the satisfaction of being able to finance his own education. Shortly after the death he became, and still remains, a student of one of father's music students. Wife's parents, both living, had prepared to divorce about the time of her engagement but did not follow through.

Mr. and Mrs. O's house is filled with pets—dogs, mice, fish—which husband purchases and helps care for with the fantasy that his wife is peculiarly sensitive and vulnerable to the loss of these pets, in fact potentially more upset by the loss of a pet than if he himself should die.

Both of his automobiles have names, first, middle, and last names. His avocation is to keep them in repair. He talks about them as follows: "They were pretty old when I bought them but I brought them back from the graveyard." He goes on to blend animate and

inanimate losses: "I tell my wife to be careful every day but what if she has been in an accident and needs help, aid, or comfort? If she or her car should be hurt or killed, I would worry because the car would be totally destroyed and I couldn't rebuild it. If you look after a machine a certain length of time, the machine has a way of looking after you."

His wife supports this blurring of distinction between life and nonlife and for Christmas gave him a nine-volume study of idols.

The attitude of one marriage partner toward the loss of a parent by the other partner varies widely. Most commonly, the fact of loss is considered peripheral. "I already have parents, I married to get a wife. It would be nice for her to have two parents but it really doesn't matter to me." Often there is a protective attitude: "She really has no one to turn to but me so we better be certain we work out our differences and not let them get out of hand." If the spouse is free enough regarding his own feelings toward loss, there are opportunities in early marriage to help the other toward coming to terms with residual fears, longing, and sadness. This seems especially true in the process of resolving anger and threats of separation. In the close couples we have seen, much of this work occurs before marriage and is one of the factors in deepening the relationship.

Around the time of marriage there is often a reawakening of interest and fantasy regarding a parent lost many years previously. This was often expressed simply as: "I wish he (or she) were here to see how well I am doing." The following is an example of the slow revival of interest in a parent after 10 years of suppression.

Mr. F's father died when F was 11 years old. Although he can remember certain events around the funeral, he has almost total amnesia about his father. He recalls going out to play football the day following father's

death and in retrospect feels this was not the proper way for him to act. He did not go to the funeral, although he does not know why. From time to time he has looked at his father's picture and recognizes him only because he has been told this is a picture of father. Most of what he remembers about his father he has been told. He has a feeling that his 15-year-old sister was supposed to have been distraught by father's death, but "no one ever told me it was traumatic for me." He says this with some resentment as if he has been cheated out of this aspect of closeness with father.

At around the time of engagement it occurred to him that his wife's birthday in November was the same day on which his father died. Before that he had not thought about his father for a long time. During the four months of his marriage he has become disturbed about his lack of knowledge of his father and has become aware that in the past he had been putting off thinking about his father and had been denying feelings. There were some clues in the interview that suppression of memory was so strong because of the fantasy that he may have contributed to father's death. In pondering about whether he was actually close or distant with father, he noted that he was appointed the "executioner" of his father's will upon turning 21. This slip was immediately changed to "executor."

His marriage is a very satisfactory one. He feels that it is his position of relative security and ease in talking with his wife that has permitted him the freedom to go back and open up some rather frightening areas.

While difficulty in separation from the family of origin is by no means limited to spouses with a loss, the common reality that the remaining parent is being left alone makes the issue more complicated.

Mrs. R's father died 1½ years prior to her marriage. As long as her mother seemed dependent, ill, or angry, Mrs. R called her daily, with a feeling of resentful obligation. In the rare instances when her mother hinted at being cheerful or seemed to be enjoying herself with her new suitor, Mrs. R attempted to break away by not calling at all. Three or four days later, her mother would call again despairing and expressing her preference for daughter's company to that of anyone else. Her husband felt put off by her mother's demandingness, was frightened by her pessimism,

and was not much help to his wife. This situation has produced two sets of plans for Mrs. R. One is to try to help mother more intensively and the other is to move to another state.

Guilt about abandonment of the surviving parent often intensifies Oedipal issues as well.

Mr. L's father died when L was 17, and he lived at home until his marriage at age 21. In a common variety of the Oedipal situation, Mr. L felt obliged to have weekly outings with his mother and wife. His mother felt displaced and angry, his wife felt undefended and unhappy, and he, while adamantly continuing to set up the situation, felt victimized.

Mr. U attempted to solve this situation before marriage. He persuaded an old male friend of the family to move in with his mother. When this seemed to work all too well, he turned to wooing not only his wife but also his mother-in-law. Despite, or perhaps because of, valentine presents, flowers, etc., mother-in-law remained reserved in her affections. After one year, among the major themes of the marriage is the husband's fury about not being fully accepted by mother-in-law.

MARRIAGE CLOSENESS AND AGE AT LOSS

Evidence for marriage closeness consisted of good verbal communication even in areas of difficulty, enjoyment and pleasure in being together and doing together, absence of problems where little hope is held for solution, feelings of knowing or understanding the other and feelings of intimacy or depth in the relationship, and the marriage relationship usually taking precedence over other considerations such as jobs, friends, or extended family.

Evidence of distance consisted of poor verbal communication, relative absence of pleasure or avoidance of being together, feelings of puzzlement or concern about the other feelings, aloofness, presence of major problems with little hope about solving them, anger often unre-

solved or of long-term duration, and outside activities given preference frequently enough so that the other spouse considered himself ignored, rejected, or bewildered. If there was not specific evidence for a given item, it went into a nonratable category. The highest possible ratings for closeness on the scale constructed from these items was 5 and the lowest —5.

The mean score for the entire loss group was 1.04 ($s=2.22$) and for the

in our control couples. Many of those wanting no children said they liked children but that to have them would be a responsibility and a burden and could not compensate for what would have to be given up in life. Others were afraid that they or the children might get hurt or injured.

More striking, however, was the extent to which couples with loss did want children. Many men, regardless of whether they had lost a father of a

Table 1
RATINGS OF MARRIAGE CLOSENESS
IN COUPLES WITH PARENTAL LOSS PRIOR TO MARRIAGE
(scale range +5 to -5)

PARENT LOST	AGE OF SPOUSE AT LOSS 0-12		AGE OF SPOUSE AT LOSS Over 12		p ^a
	Mean	s	Mean	s	
Husband's father	0.0	(2.58)	1.95	(2.46)	.002
Husband's mother	-0.71	(1.89)	0.89	(3.18)	.05
Wife's father	1.27	(2.15)	1.46	(1.71)	NS
Wife's mother	0.50	(3.10)	2.00	(2.14)	.015

^a By the Mann-Whitney U Test.

control group 0.27 ($s=1.77$), $p<.06$. The difference is just under the conventionally accepted level for statistical significance. In general, regardless of the sex of spouse or of the parent lost, the scores for marriage closeness were significantly higher for those who lost a parent after age 12 than for those whose loss was between birth and age 12 (TABLE 1). The one exception is that for wives with a loss of father, no difference was found between those whose loss was before 12 and those whose loss was after 12.

INCIDENCE OF CHILDREN

Among our loss couples 6.6% did not want any children, compared to none

mother, considered the potential of their wives as future mothers as a primary factor in selecting them as mates. Not only were the loss couples anxious to have children but they actually did have children far more frequently than control couples. 59% of the loss couples compared to 33% of the control couples had children by 27 months of marriage ($p<.05$). An additional inspection of a small group of couples which lost a parent under the age of 16, showed a similar tendency. 81% of those couples had children by 27 months compared to 37% in the controls ($p=.01$). These differences were not accounted for by racial, religious, or socioeconomic factors.

DISCUSSION AND SUMMARY

About one out of five couples in our study population drawn from the community had experienced the death of a parent prior to marriage. It has been our intention to demonstrate the range of what may be encountered in couples with such a history during the first two and a half years of marriage by describing some of the most frequent clinical outcomes and a number of illustrative phenomena.

Some of these outcomes are marriages with many difficulties, largely substantiating the consensus of the literature. That we were also able to describe quite successful marriage outcomes may be due to the fact that our sample was drawn from the community and not from a patient population as in many of the previous studies.

In the marriage types or syndromes described, there is a general relationship between the ability to sustain intimacy and the age at loss although not with the sex of the parent lost. Manifestations of anger, particularly duration and mode of resolution, are similarly related to age at loss. Impairment of sexual enjoyment in women with close marriages may be just as severe or even more severe than in women with chronically conflicted marriages. However, as seen in close marriages, sexual problems seem to be related to a fairly well-circumscribed resurgence of Oedipal conflicts previously accentuated by the death of a parent and are not related to the vicissitudes of the marriage relationship.

Couples with loss seem to show two extremes regarding children. A small number expressed a wish to have no children whatsoever. The loss population as a whole, however, had significantly more children than the control group.

In the usual development of the marriage relationship, the process of loss and the process of replacement goes on simultaneously. Loss is incomplete and can be regulated. Indeed, in a general realignment of identity and emotional investment, many people choose to come closer to their families of origin soon after marriage. No such gradual processes are available to those who lose a parent by death. Loss is catastrophic, complete, and fully outside the control of the child. In our sample nonetheless, a significant number of these children, particularly adolescents, go on to form stable and particularly close marriage relationships.

In speculating about how this may occur, let us examine the position of the adolescent who loses a parent. His or her fears that the remaining parent will die and he or she will be left totally abandoned and helpless are buffered by already developed independent skills and a network of peer relations and institutions. Guilt and anger at being left may be mitigated if the relationship prior to loss was reasonable and if the loss did not take place after chronic family discontent as it does in divorce. There is a sexual confrontation with the surviving parent but by this time sexual allegiances have already been established beyond the family. In short, the adolescent has social and developmental means, not available to children of younger ages, of handling some of the repercussions that follow the loss of a parent. Acute grief subsides but what about the feeling of longing and loneliness for the parent as a person, the wish for the relationship? We would suggest that there is no adequate resolution of these feelings for the adolescent and several years later he draws from this

pool of feelings his hunger for interpersonal closeness in marriage and perhaps also his desire to reconstitute a family as quickly as possible by having children.

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PSYCHOLOGICAL STATE DURING FIRST PREGNANCY

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Six women were studied in group, hospital, and home settings from the beginning of their first pregnancy for 15 months. Their psychological state is discussed in terms of altered field of consciousness, medical symptoms and concerns, and approaches and reactions to labor and delivery.

Obstetricians¹⁰ as well as psychiatrists⁴ recognize emotional lability, anxiety, insomnia, crying spells, etc., as common symptoms of pregnancy. Tobin¹¹ found that "the blues" were described by 84% of pregnant women compared to 26% of nonpregnant controls and that "unexplained crying" were described by 68% of pregnant women compared to 5% of the same controls. Nor is this recognition limited to professionals. Women's magazines are filled with cartoons about the quixotic character of women's demands, and modern folklore offers the image of a much maligned husband venturing forth in the dead of night to fetch a pickle and peanut butter sandwich for his craving wife.

Although the existence of unusual emotional states during pregnancy seems generally accepted, its origins are still a matter of speculation. Both animal and clinical investigations have shown that the sex hormones have strong behavioral effects suggesting that the marked progesterone and estrogen shifts during pregnancy may play a dominant role in the pregnancy psychology.¹ Others suggest that shifting id-ego relationships during the pregnancy crisis are responsible for the emotional changes and increased availability of primary process material.^{2, 5} Most writing on pregnancy, including this paper, holds to the present impossibility of separating out the complicated interrelationships between hormonal and psychological factors.^{3, 8}

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This work was carried out in the department of psychiatry and department of obstetrics and gynecology of the University of California School of Medicine under the direction of Harry Wilmer, M.D., clinical professor of psychiatry. The author would like to acknowledge his operational and intellectual guidance during the project.

This study reports on the use of a "first-baby group" in conjunction with "field observation" on the obstetrical floor and home environment as a tool for increasing our understanding of some aspects of the psychology of pregnancy and labor and delivery.

A complete description of the design and psychology of this first-baby group is available elsewhere.⁶ In brief, 14 women were randomly selected from the University of California Medical Center Prenatal Clinic early in their first pregnancy. They were all married, Caucasian, lower middle class, high school graduate, with no history of major medical illness and no history of mental illness or treatment by a psychiatrist. Each was told that the group was a place where there would be talk with other pregnant women about matters of common concern relating to pregnancy and the baby. Six became regular members and were followed regularly in once-a-week group meetings through pregnancy and, with the new infant in attendance, during the early months of mothering. Comparison of the regular group members with those contacted but not attending showed little difference in overall socioeconomic indices. However, the regular group members seemed less expectant of family or community support during the peripartum period as determined by personal interview and prenatal questionnaire, which could account for their interest in the group.

The author used an open-ended, non-directive format determined by the research aim of using a group to study the psychology of the first pregnancy—new mother and new infant—in as natural a group setting as possible. In addition to following the group's progress, he was present at labor and delivery of each

woman, visited her in the hospital on the second and fourth postpartum day, and made a home visit six weeks postpartum.

The specifics of the psychological state during pregnancy will be approached from three points of view: (1) the altered *field of consciousness* as used by phenomenology to imply changed subjective awareness toward internal and external stimuli;⁹ (2) the use of *symptoms and medical concerns* to express and communicate emotional states and preoccupations; and (3) the psychological task and function of *labor and delivery*.

FIELD OF CONSCIOUSNESS DURING PREGNANCY

The most frequent observation by the women about their own mental states during pregnancy was of overreaction to things that would not have ordinarily affected them. They were usually unable to pinpoint reasons for their reactions. Small family arguments, being frightened by a stranger, even receiving the wrong change at a store, could cause unrelenting depressions, crying spells, or uncontrolled laughter. Many of them retreated from socialization because of embarrassment at these inappropriate and extreme outbursts. Some of the more psychologically minded members ruminated about possible reasons for their feelings and gained relief when group discussions were able to isolate a particular psychological mechanism seemingly responsible for the feelings of the moment. Even when the emotional liability continued, the uncanniness of the experience seemed abated. All of the women had heard that hormonal changes were responsible for the moods and many found relief in this possibility. In spite of the other explana-

tions available, the women seemed to retain the feeling that something they had thought or done must be responsible for their strong moods.

Superimposed on this undefined emotional lability were specific experiences that would predictably call forth uncontrollable emotional reactions. For example, Mrs. D. regularly read a Catholic weekly newspaper which often had editorials chastising elements in society who were in favor of birth control and abortion. She recognized early in her pregnancy that she felt uneasy whenever she read these editorials but by the six or seven month such material reduced her to tears. During the last month of her pregnancy she was unable to read about a fetus without becoming tearful and depressed. She professed to a conscious attitude of not having wanted to become pregnant in the first place and not wanting the baby now that she was pregnant, which makes these reactions more understandable.

Discussions of death and dying, triggered by newspaper accounts of accidental deaths of children, seemed to have a continual fascination despite their upsetting nature and were compulsively brought up at many of the group meetings. Perhaps the women hoped to achieve psychological mastery through the group experience.

These women's peculiar sensitivity to such events suggests an acute openness to their environment, as if even familiar objects and events had meaning beyond their commonsense value. Language, too, seemed to take on a new set of symbolic meanings. When delivery of the baby was imminent, references to difficulty in getting out of places, opening doors, being stuck somewhere, were often accompanied by embarrassed or anxious

laughter. References to a "refrigerator so full it could almost burst" or "needing to do a thorough housecleaning one of these days" were rich with double entendre just as ordinary usage borrows imagery from pregnancy and childbirth. We "conceive" ideas and experience "pregnant" moments. Some of the "unexplained" emotional reactivity may be an appropriate responsiveness to the heightened meaningfulness of and impact of events and interactions previously taken for granted as well as to unconscious and preconscious meanings.

Another characteristic of the mental state of these pregnant women was their increased importance of obsessions, phobias, and dreams in their subjective lives. This aspect of pregnancy was for most of the women embarrassing and alien. It was only brought up in the group when someone was under great psychological pressure to do so. Perhaps the most memorable moments in the group were the few occasions when one of the women, obviously terribly anxious, would mention a "peculiar thought" that she was having or the particular frightening dream that she had had "a month ago" and then with obvious relief other women would admit to similar, usually more frightening experiences.

One woman described her dream as following her into the day and affecting her more personally now that she was pregnant. She was echoed by another who described her own needs to "go around all day trying to get it off my mind . . . getting a book and reading it to keep from concentrating on the dream." Although the manifest content of the dreams varied considerably throughout the pregnancy, their importance in the field of consciousness of

the pregnant women in the group appeared to last through most of the pregnancy. Mrs. P. was able to describe three distinct kinds of dreams occurring at different times of her pregnancy. In her fourth and fifth months she dreamt about harm coming to herself. By the sixth month most of her dreams were about catastrophes happening to her husband. In the last part of her pregnancy she began to have elaborate dreams about losing the baby after it was born and finding it dead or "wrinkled like a dried prune" on the top of some closet. This pattern of preoccupation with harm coming to oneself, one's husband, and even one's baby seemed to be true of many of the other women's dreams as well.

Four of the women had remarkably similar dreams about delivery of the baby although only Mrs. P. was present when another reported hers. All of the dreams occurred during the last few months of pregnancy, and in all there was no pain with birth. Furthermore, none of the deliveries were preceded by labor; rather, the babies either came out by themselves or were just there. Obviously none of these women had actually experienced labor, which might to some extent account for its absence in the dreams. (How do multiparous women dream about labor?) In all the dreams, the women were displaced from their usual role by the baby's arrival. Mrs. A. dreamt that she was standing on the street corner while her husband picked up the baby, while Mrs. R. and Mrs. P. dreamt their babies were already home when they arrived. All the women described the feeling of being excluded from taking care of the baby or else "willingly" giving over the job to someone else, usually their own mothers. The similarities in themes is understandable

when one reflects that each of these women were concerned about pain and loss of control about the delivery process, their untested competence as mothers, the change the baby would make, and the need to take care of rather than to be cared for. In addition, each was involved in a group experience where many of these problems were discussed.

Transient compulsions, obsessive rumination (particularly about bodily injury and personal losses), and all variety of phobias also seemed accentuated in pregnancy. For example, two weeks before delivery Mrs. D. felt the uncontrollable impulse to clean out her bathroom many times a day. Although she had been excessively neat prior to pregnancy, there was no previous history of a dystonic compulsive symptom. It disappeared soon after delivery. Car and driving phobias were exceedingly common, affecting four out of five of the regular group members who drove. Only Mrs. P., who had to drive 50 miles to come to the meeting, seemed not to have an overwhelming fear around cars, driving, and freeways and her long impractical weekly commute to come to the meetings might be considered counterphobic behavior. She even had the obsessive thought through the middle semester of her pregnancy that her husband would die in an automobile crash. The symbolic connection of one's car with one's body is well known. Fear of body damage and later body-fetus damage appeared to underlie many of the unusual mental trends seen in this group.

Once the presence of another living creature inside of them was accepted, the women seemed to identify with this new organism which shared their "inner space." Many of them were preoccupied

with stories they had heard from their mothers about themselves as helpless infants. Such memories together with their own hostility toward "the intruder" played an important role in structuring the preoccupations of the individual women.

Thus far our discussion had pursued shifts in mental experiences during pregnancy which have unpleasant connotations. It was often difficult to obtain information about positive feelings when someone in the group communicated a need for help. Undoubtedly this focus on problems was in part a function of the clinical setting and clinical training of the leader. There were many suggestions that some of the women were experiencing positive, even "peak" experiences and that some of these experiences were new since pregnancy. Many of these feelings were communicated in the group as joy at having their growing bodies admired by their husbands. Mrs. P. described the radiance she felt in her husband looking at her approvingly "as I clambered up the stairs in my new awkward way." Some alluded to heightened sexual and intimacy feelings. Many spoke about their new-found opportunities to "make things happy" for another person, often in relation to some of their own unhappiness as children. One sensed a growth of personal confidence and transition from frightened "daughters" to women.

MEDICAL SYMPTOMS AND CONCERNS

All pregnancies in all societies carry the certainty of new physical sensations, the expectation of discomfort, and the fear of complications, even death. Despite our society's low perinatal mortality, perhaps because of the present im-

portance of medicines and medical personnel in the processes of pregnancy and delivery, the conversations in the group suggest that medical symptoms and concerns were the most common means for the women to express and communicate the pleasant and unpleasant ideas and emotions centered around their pregnancies.

In the very first meeting Mrs. D. described "being so sick that I didn't even want to be pregnant—I'd just lie next to the heater and want to die," and the rest of the group joined in about the physical sensations they had or hadn't experienced. Early morning sickness, unexplained tiredness, and particularly weight gains and diets were focused upon as something they all shared and could talk about with relative ease. A rundown of the symptomatology of the previous week and how the doctor or husband had dealt with it became almost a group greeting ritual. Similarly, questions of medical concerns such as, "Shouldn't the baby have kicked yet? . . . Will he kick a hole through me? . . . Can you hurt the baby by running fast? by having an Rh blood type? by having intercourse?" were repeatedly raised, independent of whether the answers were known by the questioner. It was often possible to uncover some of the specific difficulties expressed through a particular symptom or question and to trace changing use of the symptoms to express new emotional difficulties as the pregnancy progressed. An analysis of the problem of weight is relevant since it was a very common group concern throughout the pregnancies.

Weight gain and overeating may have symbolic connections with the baby. This association is commonly seen in children's pregnancy fantasies and in the

oral-impregnation fears in anorexia nervosa. During pregnancy these connections may be quite conscious. Early in the pregnancy, weight gain and fetal growth parallel one another. Weight gain may be used for reassurance about the fetus' viability and normal growth. Mrs. D. explained her excessive weight gain to the group in this way: "I've gained 24 pounds in the 4½ months—the doctor kept telling me not to gain any more." Then she sheepishly added, "You know maybe it really isn't fat, maybe it's the baby—couldn't the baby be the weight? I know it couldn't be, but the fat is awfully hard, particularly at night." After baby kicked and she could feel its outline in her abdomen, her weight leveled off.

Weight was often brought up in relation to the problem of control for women in the fifth month of pregnancy when the baby began to kick. For example, Mrs. A. commented in a discussion which had begun with talk about the sensations of the baby first kicking, "You know, dieting is something you can control while the baby isn't." On another occasion Mrs. M. expressed the group consensus when she complained, "The diet the doctors give you is enough to kill you. The damn thing inside of me eats better than I do." Many of the events of pregnancy, for example the kicking fetus, are beyond conscious control. Weight is one of the few relevant physiological areas left within their influence. Ironically, it is also the prenatal variable which is stressed most heavily at each clinic visit. For some women, weight can be a way of asserting themselves against their doctor's authority and indirectly against their husband and even their future baby.

In the third trimester the topic of excess weight gain and dieting was less

often raised. When brought up, it seemed to relate to the real and imagined extra problems it might produce in the course of labor and delivery. Weight loss after the delivery was discussed in relation to regaining the prepregnancy figure. Most of the women were surprised at how slowly they regained their previous form and resented still looking pregnant. However, these discussions were often tinged with nostalgia for their pregnant shape and the special status and privileges it secured. Mrs. P., who had gloried in her pregnancy and became depressed some months after her delivery, used the weight loss topic to comment on the loss of closeness with the baby after delivery. In these examples, weight was used to express a variety of feelings during the course of pregnancy and to have specific communicational and symbolic meaning.

Sometimes one could trace the use of many symptoms, each consistent with the stage of pregnancy, to express a single preoccupation. For example, Mrs. P. experienced the first half of pregnancy as idyllic, treasuring each moment despite the realistic worry of being a Jehovah's Witness in a clinic which she knew had gone to court successfully to be allowed to transfuse a Witness who was felt to be in mortal danger. She also knew of Rh incompatibility with her husband, although she was told that this was not a problem in a first pregnancy. When her 9-year-old stepdaughter was killed in an auto accident, she continued to describe her own pregnancy in glowing terms, although she felt guilty over her joy "in a new life" which she was bringing into her family where one had just been lost. When her baby began kicking, she seemed less euphoric, particularly about mothering capabilities. Many of her positive attitudes and feel-

ings changed. No amount of reassurance or information stilled the fear that something would go wrong with her baby. In her ninth month she felt sure she would not deliver the child normally because the doctor had told her she had a "broken sacral vertebrae." (There was no mention of any abnormality in the patient's chart.) She developed a moderate back pain, her first uncomfortable physical symptom of the pregnancy. After her normal delivery Mrs. P. seemed to have forgotten her fears.

Mrs. P's endless questions about the baby's "wrong positioning," Rh factor, sacral spine difficulty, and finally her symptom of back pain developed in parallel with the physiological timetable of potential difficulties and seems to have been derived from the single fear of harm coming to the new child, understandably in the context of the tragic death of her stepdaughter.

LABOR AND DELIVERY

Many hours of group discussion centered on planning for the labor and delivery experience. These discussions suggest that each woman entered the labor room with a psychological task valued as only slightly less important than the safe exodus of the baby. This task varied from a need to "do it for oneself" through actively spurning the help of the doctor, to the need to put oneself in the medical staff's hands and not participate actively in any manner. By observing during labor I saw a distinctive performance style for each woman or couple. While the labor proceeded it was possible to see the "plan" unfold and to evaluate its relative success or failure.

For example, Mrs. O. spent the greater portion of her time in the group

talking about how she would like to handle labor and delivery. She antagonized most of the women by asserting that natural childbirth was the only way to fully experience oneself as a woman and seemed hesitant about assigning to the nurses and doctors any role whatsoever. She also felt that husbands should be included in labor and at delivery and was in constant battle with the clinic personnel over their excluding the father. She joined a natural childbirth class in her community and felt dissatisfied by their dissemination of information about pain medication and anesthesia. She saw labor as she had seen most of the tasks in her life, as opportunities for further reassurance about her ability to handle things by herself. She feared losing control.

She had always lived alone, shunning help and dependence. She was most comfortable when "in control" of her marriage. She was little interested in the coming baby, and forced herself to accept the baby furniture given to her by friends. Her thoughts were focused on the delivery process. The rest could wait.

Her husband was with her for the 19-hour labor, refusing to leave, even for the doctor's pelvic examination or for the "prep" by the nurse. His behavior caused considerable consternation and anger in the attending staff. Mrs. O. was in control throughout the long day and refused final anesthesia and all but one pain medication offer. She pushed the breech presentation baby through without the need of high forceps. Only minutes after delivery she felt she had let herself down by having taken the small amount of pain medication during labor. For the first two months postpartum her thoughts seemed to be as much on her performance in the labor

room and delivery suite as on the new infant.

Mrs. O's case used labor and delivery to control the unknown. She projected the potentially anxiety-provoking experiences of pregnancy and the unknown demands of motherhood onto the labor and delivery. Her feelings were summed up by the advice she gave to one of the newly entering pregnant women when she was three months postpartum. "You should try and pretend you're not pregnant at all and just try to prepare yourself to get through the delivery. The rest will take care of itself."

Like weight, labor and delivery are aspects of pregnancy over which women may have some degree of knowledge and control. Preparation classes serve the psychological function of providing a sphere of competence and confidence balancing the unknown and uncontrolled aspects that predominate. Individual control during labor and delivery are also ways of resisting the temptation to rely completely on the physician at a time when so much effort is being spent in readying oneself for new, more responsible, and independent roles.

Most of the women actively sought dependence on the doctor and hospital. Reliance on "science and medicine" was a part of the clinic culture, and there was considerable pressure to conform. Some women dealt with the fear of pain or loss of control by asking "to be put to sleep" or "not wanting to feel anything." Mrs. Mc. and Mrs. D. both tended toward this pattern. They shunned all exercise classes and were upset and dismayed by Mrs. P's attitude. During labor both complained of continual pain despite maximum medication. They had little emotional investment in proving their independence or remaining

in control and seemed more comfortable with dependency in their marriages and family relationships. Both relied heavily on their mothers in the postpartum period. They talked little of their experiences afterward, except to chime in with the martyred woman's commiserations on the maternity ward and in the group.

Much of the context of group discussions focused on labor and delivery suggested the importance of unconscious and symbolic determinants of labor and delivery behavior. Childhood fantasies, such as those of anal deliveries, may figure prominently in the obsessive cleanliness sometimes seen in predelivery behavior in feelings about enemas. Irrational fears and defenses merge with real fears of mutilation and death. Anxieties about the coming baby and about maternal competence are displaced to the labor and delivery process, much as the beginning of many unknown tasks, military service, or college study are heralded by elaborate greeting and orientation rituals. As one woman said a week before her expected date of confinement, "At least now I can concentrate all my energies worrying about getting through the delivery. I can almost stop thinking about that stranger from another planet who will soon be here."

It appears that a close fit between a woman's ideal expectations and actual performance during labor and delivery is an important source of positive feminine self-esteem probably crucial at the threshold of motherhood. The clinic culture defines successful completion of the labor and delivery task as following the standard practices with regard to husband involvement, pain medication, spinal anesthesia, etc. Most of the women have made this expectation their

own. This equilibrium is upset when for a variety of reasons a woman defines her success by conditions opposed to the usual obstetrical routine.

COMMENTS

The psychological profile of first pregnancy that emerged in this study should be tempered by consideration of the impact of the first baby group experience on each of the women. Certainly the group accentuated the "pregnancy identity," and the clinical setting and psychiatric leadership may have slanted the reported experience and behavior. On the other hand, it would be a mistake to interpret the findings as indicating emotional disturbance in the group members or the subsample of clinic primiparas of which they are part. In fact all the women studied seemed to have adapted well to the shifting stresses placed upon them by the pregnancy and new infant as manifested by their family self-appraisal of the experience, their lack of need for psychiatric intervention, and the opinion of obstetrical and well-baby clinic staff.

One of the most important findings of this study was that in order to evaluate the prospective mother and make sense out of the form and quality of her postdelivery adjustment, the "total pregnancy system" rather than the "clinic-visiting woman" must be studied. For example, one of the key determinants of this "system" is the husband's reaction to the pregnancy. In effect the father-to-be must accept his wife's ever-changing shape and endure sexual privation or return to modes of sexual expression which are less fulfilling or, if pleasurable, may be threatening to masculine self-esteem. He is asked to mother his wife so that she can accept the coming mothering responsibilities for the

child. Throughout his wife's pregnancy he is being asked to give up pleasures in exchange for responsibilities. If, prior to the pregnancy, a large part of the marital relationship has been based on the husband's gratifying his dependency needs with a mothering wife, he may be faced with a difficult adjustment by this shift in the dependency balance even before the child is born. Unlike his wife, he receives little immediate gratification from the newborn and yet he is expected to give a great deal, even to society at large which expects cigars from him. He may feel envious of her creativity and feel impelled to create on his own by pouring increased energy into premarriage success patterns. In other words, the husband too finds himself in the midst of a crisis, and his movements toward growth or regression will profoundly influence his wife's adjustment.

The husband's reaction to the pregnancy and new infant is only one of the additional variables in the complex equation needed to describe the family adjustment potential. The quality of relationship with the secondary families, the proximity of helpful friends and even the physical home environment might all need to be evaluated to understand, let alone predict, the direction of outcome.

Any prediction of outcome must be based on a knowledge of the pregnant woman's behavior in a variety of situations, of her home, and of her husband, as well as of her individual psychology. It was striking how often a subject's behavior in the group or hospital differed from her behavior in her own setting and how often attitudes shifted when the husband was present.⁷ The pregnant woman, perhaps because she is in the midst of multiple successive

crises, is peculiarly open to environmental and social influences, an environment which is itself continually shifting with the strain of change.

This openness to environmental influences also provides an opportunity for the prenatal and well-baby clinic to have beneficial impact on the new family. This has become increasingly important in our own rapidly changing society where, unlike cultures with relatively static living conditions where mothering patterns may suitably be handed down from mother to daughter, we must help mothers prepare their child for *his* and not *his grandmother's* world.

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THE SOCIAL AWARENESS OF AUTISTIC CHILDREN

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Interaction was observed in a day setting for autistic children. It was posed that if autistic children were unresponsive to social cues their behavior would not be socially patterned. Analysis of interactions showed both workers and children to be highly responsive to each other and to context.

This paper represents the beginning of an observational study of autism as a social phenomenon. It is our assumption that by observing and studying social behavior as such, including both the social context and interaction patterns, we may come upon some undiscovered aspects of the phenomenon defined as "autism."

The people who decide that a child is disturbed and the professionals who diagnose the child make these decisions on the basis of overt social behavior.⁹ Yet we find that in most studies of disturbed children the overt behavior is interpreted according to some theory of internal functioning, in particular "impaired ego functioning." Goldfarb, Braunstein, and Lorge⁴ and Goldfarb,³ for example, refer to various types of

nonconforming behavior among schizophrenic children as examples of failure in ego-adaptive functioning. Redl and Wineman⁷ also refer to disturbance of the ego function when they describe aggressive children.

The interpretation of unusual or "strange" behavior as a failure of ego function—particularly in relation to perception of and adaptation to reality—is general not only among social scientists but among members of society as well. The interpretation is reflected in such expressions as "out of contact," "out of it," "far away," and "not in contact with reality." We find these notions (which we will summarize as "not in contact") also used by people who work directly with autistic children.

There is some questioning in the liter-

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ature as to the validity of this notion and its scientific equivalents for describing the experience and behavior of the person defined as autistic or schizophrenic. Stanton and Schwartz,⁸ Goffman,² Laing,^{5, 6} and Szasz⁹ each suggest that psychotic persons may in fact be very much in contact with social situations. Some questions have also come from investigators concerned with autistic or schizophrenic children. Boatman and Szurek¹ report:

The most marked symptom of many of these children is their *apparent* unresponsiveness to other people. On closer observation, it can be seen that they are actually and minutely aware of all that occurs, particularly on the part of meaningful adults. [Stress is theirs.]-p. 395.

Boatman and Szurek also suggest that though these children seem to lack ability, it is more likely that they are engaging in resistance. Resistance would imply an understanding of expectations and an orientation to the interaction situation. The data we shall present exhibits such resistance in action. Boatman and Szurek¹ and Szurek¹⁰ conclude that the children behave in paradoxical ways. Others such as Goldfarb, Braunstein, and Lorge,⁴ Redl and Wineman,⁷ also report some "in contact" behavior among children diagnosed as defective in ego functioning. They explain this by "selective impairment." The basis for the selectivity is left unclear.

We begin by questioning the assumption that such children's behavior can be characterized as "out of contact," or that their functioning can be regarded as impaired. Such an assumption tends to overlook or distort the situational and interactional components of social behavior and the interpretive nature of human learning and use of symbols. In place of this rather narrow focus, we

choose to emphasize the intimate connection between human actions and the social settings of these actions. By paying systematic attention to this connection, we have found that *the behavior of autistic children is just as oriented to social context and interacting other as the behavior of normals.*

SETTING AND OBSERVATIONS

The setting for our observations is a nursery day school for children defined as disturbed, particularly "autistic" and "schizoid personality." The school is staffed by four nonprofessional workers, occasional volunteers, and a director and co-director. There are 10 children, nine boys and one girl, ranging from 4 to 7 years old, the majority being 5. The children are in school five mornings a week, arriving at 9 a.m. and leaving after lunch to return home. The school program is primarily recreational, with some structural activities and some free play under the supervision of workers.

The following observations from our notes suggest that the children involved, in spite of their generally withdrawn appearance, are very alive to the situation in which they find themselves:

1. Kenny at music time is continually involved in "symptom behavior"—weaving back and forth in his chair, making hand movements specific to him. He has never been seen by observers to show behavioral involvement at music time. Yet he learns the songs perfectly—he has been heard at times other than "music time" singing in perfect tune with words clear as a bell and with adult pronunciation. Otherwise, Kenny rarely speaks, and when he does it is difficult to understand because he does not enunciate and tends to sound as if he can not quite form the words.
2. Outside, Joe is tapping his head with a toy shovel. Mrs. Jean goes to Joe. "Joe, the shovel is for digging, not for hitting." He ignores her. She takes the shovel from him, and walks away saying, "It's too hard; it's for digging. . . ." He looks at her, laughs and

begins playing with some styrofoam. A few minutes later, he chews a piece of styrofoam. Mrs. Jean sees him and says, "Take it out of your mouth, out of your mouth." She starts toward him; he takes it out. She says, "That's right." When she turns her attention away he puts it back into his mouth. She looks up and sees it. "No, spit it out, out, no." He looks at her but does not spit it out. She comes to him and takes it out of his mouth. She takes the styrofoam away to the shed. He gets up smiling and walks away.

To document our impressions, we now focus on a detailed study of one kind of child-worker interaction in order to show how autistic children do exhibit awareness and meaningful behavior. We will use child-worker interactions in which the worker gives a command to the child.*

COMMANDS

The activities which go on in the school, the limits set, and the kinds of interactions which occur involve attempts to create a setting in which the children will learn to act "normally." This normalization process is enacted when the worker brings the child's behavior into gear with the structural requisites of the school, with the interactional and solitary behavior felt to be normal by consensus or director's dictates, and with the normal expectations of the individual workers. Commands are important because they involve such direct confrontation between the worker and the child. It is through this confrontation that we will discover the children's awareness or lack of awareness of social reality.

Command is here defined as a worker-initiated interaction sequence with the

following attributes: (1) worker and child are not engaged in mutual interaction before the command is given; (2) worker approaches child and tells, asks, or physically forces the child to do something.

We conceptualize the command situation as a "sequence of behavior" divided into three logically related segments: the situation immediately preceding the command; the giving of the command; and the outcome of the command.† An example is the following encounter between one of the children, Stan, and a worker, Mrs. Rena:

PRE-COMMAND: Benches have been assembled for singing. Stan is standing near the benches. He is agitated: his fingers are in his ears, he is whining. He has the rope he has been carrying all day. **COMMAND:** Mrs. Rena comes to Stan and says in a harsh voice, "Be quiet!" **POST-COMMAND:** Stan walks over to the benches, sits down, and continues to whine.

To study the behavior in each sequence, we examined the following activities:

1. *Pre-Command Situation:* Here we studied the "observed accessibility of the child's behavior," or our perception of what the worker is thinking when she gives a command. Does she see the child as deeply involved in some activity, making it difficult for her to obtain his compliance, or as not involved and thus more easily persuaded to attend to the command? In the illustration above, Stan is not only highly agitated but also deeply involved in playing with his rope. Thus it appears that in Mrs. Rena's estimation he will not be easily accessible. We dichotomized "observed accessi-

* From among our observations, a total of 23 commands involving two children were selected for study. All commands observed in a three-month period were used.

† Here we should like to make it clear that no precoding of the command situations was done. The categories developed out of our observations rather than vice versa.

bility" into: child's behavior seen as accessible, and child's behavior seen as *not* accessible.

2. *Command Situation*: Here we use the *form* of command given and the *situational context* surrounding the command. Form of command includes the tone of voice and physical gestures accompanying the command.

Form is ranked on a continuum from persuasive to harsh. Persuasive commands are invitational calls, soft vocal requests, and simple vocal commands, while harsh commands are declarative ought statements, firm strong tones, harsh shouts, or physical commands. Mrs. Rena's loud "Be quiet!" in the example above is a harsh command.

Situational context refers to the value given by workers to different social activities in the school. Our observations indicate that lunchtime and musictime are relatively valued, dancetime and unstructured free play relatively devalued. These evaluations appear to be made on the basis of activities workers consider important for "normalizing" the children and personal alignments that develop among the workers.*

3. *Post-Command Situations*: The outcome of the command is conceptualized as whether or not the child complied with the command. We also recorded expressive behavior accompanying the child's response. These behaviors are: gestural (smiling, screwing up one's face, shutting ears with fingers); vocal (moan-

ing, crying, singing, mumbling); positional (moving away, moving closer); and physical contact (manipulating the other's body). In the example above, Stan's continued whining and his walking away indicate a response of noncompliance accompanied by a positional "move away."

METHOD OF ANALYSIS

Behavior of normals, such as workers in our school, is differentiated according to social context. That is, it is socially oriented and patterned. If autistic children were out of contact then we would not expect such orientation. We shall look at the children's behavior in relation to context and see how it compares in terms of social orientation to the behavior of normals such as workers. If we find any social pattern in the children's behavior this would indicate that the children are aware of the different situations they are in and differentiate their behavior accordingly.

Using our conceptualization of worker-child interactions as sequences, we will first examine the workers' behavior.

WORKERS' BEHAVIOR

Orientation to Others: Workers use different commands depending on how accessible or reachable they perceive the children to be. Our data show that workers rely almost exclusively on persuasive techniques when the child appears accessible and resort to stronger

* This impression is substantiated by the following two examples:

1. Observer was talking to the co-director who said that Maxine, the dance teacher, was leaving and added that "She was never one of the group."

2. During the staff meeting, Maxine said she got angry when other workers let children disrupt her dancing class. Ann, an older member of the staff, argued aggressively that she could not see why the children shouldn't interrupt dancetime, that since it was all for fun anyway the children should be able to run around. It is interesting that this argument was never used to sanction running about during musictime, where such behavior is not allowed.

Table 1
RELATIONSHIP BETWEEN ACCESSIBILITY OF
CHILD AND FORM OF COMMAND^a

FORM OF COMMAND	PERCEIVED ACCESSIBILITY OF CHILD		
	Accessible	Non- accessible	Total
Persuasive	8	2	10
Harsh	0	13	13
Total	8	15	23

^a Fisher's exact test score was .00009, i.e. there is less than once chance out of 10,000 that this table would have been obtained had there been no relationship.

methods when the child appears not accessible. Two examples illustrate this relationship.

1. Child perceived as accessible, worker used persuasive command:

PRE-COMMAND: Mrs. Rena was lighting a cigarette. Stan was wandering back and forth, humming to himself. COMMAND: Mrs. Rena had a lighted match and called Stan invitingly, "Stan, come over and blow out the light."

2. Child perceived as nonaccessible, worker used harsh command:

PRE-COMMAND: Stan was agitated, pacing back and forth constantly making noises. COMMAND: Mrs. Rena went up to Stan and said in a very harsh voice, "Stan! Be quiet! Stop making that noise!"

TABLE 1 demonstrates this almost perfect relationship between form of command and perceived accessibility.

Orientation to Context: Our data show that the form of command the workers choose to use depends at least partially upon the situation in which the command is being given. In contexts considered less important, such as dance and unstructured time, persuasive commands tend to be given. In contexts considered highly important, such as lunchtime and musictime, harsh commands tend to be given. Two examples illustrating this relationship follow.

1. Less valued context, worker used persuasive command:

PRE-COMMAND: Miss Maxine is conducting a dancing class. Stan walks over and moans repeatedly. COMMAND: Miss Maxine asks him to sit down; he does. He sits awhile, then gets up. Miss Maxine softly says, "Stan, please sit down."

2. Highly valued context, worker used harsh command:

PRE-COMMAND: Lunchtime. Children's names are called to get their lunches. Mickey runs to the closet where the lunches are kept, before his name is called. COMMAND: Mr. Ronald orders him back in a strong tone.

TABLE 2 shows this relationship.

Table 2
RELATIONSHIP BETWEEN CONTEXT AND FORM OF COMMAND^a

FORM OF COMMAND	SITUATIONAL CONTEXT		Total
	Less Valued (Unstructured & Dancing)	Highly Valued (Lunch & Music)	
Persuasive	7	3	10
Harsh	1	11	12
Total	8	14	22 ^b

^a Fisher's exact test score for this table was .005.

^b There are now only 22 cases; one was eliminated because its context was unknown.

CHILDREN'S BEHAVIOR

According to conventional conceptions about "autistic" children, one would expect their behavior to be consistently "withdrawn," "autistic," or random. Yet when we examine their responses in command situations, we find that this is not the case. Like the workers, the children take account of the context and the behavior of others.

Orientation to Others: Examining the data on children's responses to commands, we find that the children's behavior is influenced and patterned by the workers' behavior. The children vary their responses according to the type of command the worker gives. When the workers use persuasive commands, the children tend to comply. When harsh commands are used, they tend not to comply. Here are two examples.

1. Persuasive command is used; child complies:

COMMAND: Mrs. Rena is putting toys away. She calls to Stan in a soft voice, "Put them in, help me, Stan." POST-COMMAND: He comes over and puts two toys away. He leaves.

2. Harsh command is used; child does not comply:

COMMAND: Mrs. Rena went up to Stan and said in a very harsh voice, "Stan! Be quiet! Stop making that noise!" POST-COMMAND: Stan continued to be agitated, and continued to walk in front of the two windows.

This relationship is shown in TABLE 3.

Orientation to Context: The children vary their responses to commands depending on the context in which the command is given. In contexts less valued by workers, compliance appears to be the rule, while in contexts highly valued by workers, noncompliance

Table 3
RELATIONSHIP BETWEEN FORM OF
COMMAND AND CHILD'S RESPONSE^a

CHILD'S RESPONSE ^b	FORM OF COMMAND		
	Persuasive	Harsh	Total
Comply	7	4	11
No compliance	3	9	12
Total	10	13	23

^a Fisher's exact test score for this table was .07.

^b Since we are using commands given to two children, one can ask: Is the distribution in this table due solely to the behavior of one child? Looking at each child separately, we find that the distribution for each child is congruent with the distribution of the two children combined.

seems to be a more characteristic response. Two illustrations follow.

1. Less valued context (dancing), child complied:

PRE-COMMAND: It is dancetime. Stan is walking near and watching silently. COMMAND: Mrs. Rena brings a chair and tells him to sit. POST-COMMAND: Stan makes faces, starts to the chair, moves away, then comes and sits quietly, his fingers in his ears.

2. Highly valued context (music-time), child did not comply:

PRE-COMMAND: Mickey was involved in playing with some wooden pegs. COMMAND: Mrs. Rena comes and says, "Mickey, it's music-time. We have to clean up." POST-COMMAND: Mickey does not clean up, instead tries to get some toys out of the cupboard.

TABLE 4 illustrates this relationship. In less valued contexts, all but one of the children's responses were compliances. In highly valued contexts, almost three-fourths of the children's responses were noncompliances. All those children who did comply during lunchtime and musictime exhibited negative expressive behavior such as moans and "move aways," with their compliance indicating they did not want to comply.

Table 4
RELATIONSHIP BETWEEN SOCIAL CONTEXT AND CHILD'S RESPONSE^a

CHILD'S RESPONSE	SITUATIONAL CONTEXT		
	Less Valued (Unstructured & Dancing)	Highly Valued (Lunch & Music)	Total
Comply	7	4	11
No compliance	1	10	11
Total	8	14	22 ^b

^a Fisher's exact test score for this table is .01.

^b There are now 22 cases; refer to TABLE 2.

DISCUSSION OF FINDINGS

We demonstrated that workers pattern their behavior according to child's accessibility and context (using persuasive commands when the child is accessible and context is less valued and harsh commands at other times). Orientation and patterning was not expected of the children's behavior. We reasoned that if these children were in fact unaware of, and unresponsive to, social reality, their behavior would be consistently withdrawn or random. Examination of data on the children's responses to commands demonstrated that this was not the case; we found that the children's behavior is socially oriented in the same way as the behavior of the normal workers—they comply when persuasive commands are used and when context is less valued and they do not comply in other settings. Such striking similarity between the patterning of the workers' and the children's behavior indicates that these children are indeed aware of and meaningfully responding to the social world in which they find themselves.

Given the above, however, one may raise two questions. First, in view of the relationship between the workers' estimate of the child's "accessibility" and her use of "persuasive" commands, may it not be the child's accessibility

that determines his obedience rather than the type of command? Second, may his compliance in "less valued" situations not be a result of his social perceptiveness but rather his response to "persuasiveness" (the tactic used in less valued situations by workers) which in turn depends on his "accessibility?"

The first point: is it accessibility which determines the child's obedience rather than type of command? If accessibility determines obedience, what determines accessibility? We suggest that context is the important determinant of accessibility. As TABLE 5 shows, in less valued contexts the children are perceived as accessible whereas in highly valued contexts the children are perceived as not accessible.

In this case response to command may indeed be influenced by the child's accessibility but both his accessibility

Table 5
RELATIONSHIP BETWEEN SOCIAL CONTEXT AND PERCEIVED ACCESSIBILITY OF THE CHILD

PERCEIVED ACCESSIBILITY	CONTEXT		
	Less Valued	Highly Valued	Total
Accessible	6	2	8
Not Accessible	2	12	14
Total	8	14	22

and his response are shown to vary with context (for the relationship between child's response and context see TABLE 4). Since the children's behavior (including accessibility) does vary with context, this indicates that the children are actively responding to social cues, that their actions are not simply a reflection of their being accessible or not accessible at a particular time.

However, since "child's accessibility" is actually our perception of the way the worker sees the child, it is possible that our perceptions are wrong. The children may be randomly accessible. If this be the case, accessibility as a factor drops out and we are dealing strictly with responses to context—worker's evaluation of context and the children's responses to the compound messages coming from both the worker's feelings about context and the type of command she gives. In this case the children again are shown to be responding to the social situation through their differential responses to interwoven cues coming from the workers—evaluation of context and choice of command.

The second point is: compliance in less valued situations may not be a result of the child's being in contact but rather of his response to persuasiveness—persuasiveness being dependent upon accessibility. In terms of accessibility the question has been answered above. As far as the child being responsive to persuasiveness as such, we see such response as necessarily involving the perception of and use of social cues.

The children's behavior is not surprising. They are oriented towards the social environment in terms of their felt needs and interests which are not the same as others and they regulate and adapt their behavior in relation to these felt needs

and interests. For instance if one is using the tactics of avoidance, negative response in situations valued by workers makes social sense. Such negativistic behavior has been said to be typical of autistic and schizophrenic children but the social meaning of this behavior has not been clarified.

Further, there appears to be collusion: the workers and children seem to have an unspoken agreement in which each party knows that certain types of behavior will be responded to in certain ways. The children assess the situations they are in, and tend to vary the type of responses they give. The workers gauge their own behavior accordingly. The children correspondingly come to be aware of differences in the workers' assessment of, and behavior in, different contexts and, like the workers, they gauge their responses accordingly.

Collusion occasionally breaks into a power struggle between the workers and the children. This occurs during music-time when workers, constrained by the structural requirement of maintaining order, must allow the child to get his own way. As our data has shown, workers tend to use harsh commands during music-time to obtain compliance. If the child complies, all is well. However, if the child does not comply during music-time and "puts up a fuss" such as screaming, crying, jumping around, and general tantrum behavior, the worker will not risk having him disrupt order to an even greater degree and will leave him alone. So the worker will impose a command on the child only insofar as the command works. If it serves to increase the child's disruptive behavior in a setting which does not tolerate disruption, she lets the child do as he pleases. In these instances, then, the

child can and does have the last word. These are the times when the child typically does not comply with commands.

There appears to be a process of mutual awareness on the part of the workers and the children, each taking account of and being influenced by the behavior of the other. The children are not unknowing, passive beings who are acted upon but do not themselves act. To the same extent, and in much the same manner as the workers, the children are "in contact with" and meaningfully respond to the behavior of others and the social situations in which they find themselves.

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DIFFERENTIAL ASSESSMENTS OF "BLINDISMS"

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"Blindisms" refers to repetitive or bizarre behaviors occurring in the blind population. Often seen as inevitable, their etiology and psychological significance has received little attention. A longitudinal study of infants blind from birth offers examples of adaptive, transitory, and pathologically fixated "blindisms" with etiology comparable to related behaviors in sighted children.

Anyone who works with blind children shortly becomes aware of the existence of a number of repetitive, stereotyped, or idiosyncratic activities that are commonly grouped under the heading of "blindisms." This term includes a wide variety of activities, ranging from minor head and hand motions (e.g. head turning, eye rubbing, unusual hand postures) through varied rhythmic postural activities (body rocking, rhythmic swaying) to highly complex, ritualistic patterns reminiscent of the activity of severely disturbed (autistic, schizophrenic) children or adults.

These behaviors have been a continual puzzle to workers with the blind, and many attempts have been made to understand them and to evaluate their relative importance in the overall functioning of the blind person. Frequently such behaviors do not come to the

attention of professionals working with the blind children until the child is approaching school age, and so reports and observations of so-called "blindisms" rarely extend to ages below these earliest school years. There has, therefore, been little opportunity to consider the possible etiology of behavior patterns of this sort in the earliest years of life.

For the past three years, the Child Development Project at the University of Michigan has been engaged in a longitudinal study of infants blind from birth. This project was designed by and is under the direction of Selma Fraiberg of the Department of Psychiatry at the University of Michigan, and is a continuation and extension of Mrs. Fraiberg's work with blind children begun in 1960.^{6, 7}

The babies selected for this study are

either totally blind or have minimal light perception. As far as can be ascertained through complete medical examination, the babies have no other sensory deficits and no signs of central nervous system damage. The babies are followed through twice monthly visits to the home, during which time film records are obtained and continuous observational notes of the babies' behavior are taken by a trained observer.

In the course of this longitudinal study of infants blind from birth, we have observed over a period of time behaviors that have similarities to those typically called "blindisms" in older children. An intensive examination of our case records and films, with the aim of charting the onset and character of mannerisms like those described above, has led us to some interesting observations and to the formulation of some tentative hypotheses regarding their meaning and relationship to the developmental problems of the blind child.

While such mannerisms seem to have a certain similarity across a population of blind children, a careful examination of typical behaviors in each child over time (during the first three years of life) indicates that the problem of origin and meaning of such mannerisms is a highly complex one and varies greatly from child to child. In our own sample of 10 infants, frequency of occurrence of such behaviors ranges from one child who showed none at all over his first two years, to one child who, in his second year, became markedly engrossed in a series of stereotyped, repetitive activities that persisted over many months and usurped a major portion of his attention and energy. Between these two extremes, there are instances of a variety of behaviors similar to "blindism"

behaviors that occur at particular times and for varying lengths of time in the individual child's history.

As a basis for the consideration of the diverse origins and the possible meanings of so-called "blindisms" we have chosen illustrative case materials from the histories of three congenitally blind infants who have been followed by the Child Development Project from some time in their first year of life through the succeeding one to two years, depending on the time of the child's referral to the project. The examples chosen represent three quite different behavior patterns each bearing little resemblance to the other. In each case, however, we began to see that if these behaviors were to persist over a two-to-three year period, they would develop into firmly entrenched mannerisms or sets of mannerisms that could fall under the general classification of "blindisms."

KAREN

When we first saw Karen at 11 months of age, we were very concerned about her hands. They looked peculiar, useless, almost dead. Most of the time they were up near her shoulders, bent back at the wrists, half-closed. Occasionally when she was upright, she swept at the space behind her head in a strange, apparently purposeless way. To us, this hand posture and arm motion were potential danger signs. They indicate, too often, a long history of inadequate or insufficient contact with important love objects and a related inadequacy of experience in using the hands to explore and to learn about the world around her.⁸ If intervention were not effective soon, it seemed all too likely that Karen would become increasingly out of touch with her environment and thus increasingly

unresponsive to efforts to help her.

Karen is a retrolental fibroplasia baby. She was premature and very small at birth, weighing only two pounds, three ounces. Her smallness and prematurity caused her parents great anxiety. It was two months before they were permitted to take her home from the hospital. Another two months passed before they learned that she was blind. The parents cared for her as best they could, but with no experience, with no help or advice, and unfortunately with little intuitive feeling for the needs of an infant, this young couple unwittingly created an extremely monotonous and understimulating world for their firstborn child.

Karen was stiff and uncomfortable when held, so they handled her as little as possible. They fed her with a propped bottle, kept her warm and dry, and felt that she was an undemanding baby and easy to care for. Since they thought all babies did nothing but eat and sleep for the first year, they had no way of knowing how far behind Karen was falling in her development. As her first birthday approached, however, they began to be concerned about her. They worried about whether she would learn to walk or talk as she should, and about other things as well. For instance, there was nothing she seemed to care about. She did not search for things she dropped, and she seemed generally unresponsive to toys or other objects around her. At 11 months, Karen still slept all night and most of the day.

When she was awake, she spent most of her time in her several infants seats (a wind-up swing, a rocking horse chair, and a bouncing seat). In these seats, there was nothing to play with; toys would immediately fall from the narrow trays and there was no way for her to

find them. Sucking on her pacifier, she clutched the cross bar in front of her and rocked or bounced, and often she seemed frightened when put down elsewhere. While Karen was held on her mother's lap, at our request, she seemed both apprehensive and uneasy. When Karen grew tired or bored with her activity in the infant seats, she was returned to her crib to sleep some more.

If Karen's hands offered us our first clues to her past difficulties, they also gave us indications of change and progress through the next half year. During our weekly visits to Karen and her mother, we took every opportunity to demonstrate that Karen could be perceptive, that she was interested in toys, that she did care and try. At first the signs were tentative and hard to notice unless watched for carefully. Sometimes they were difficult to understand for the reaching attempts they really were.

This was especially so with the odd sweeping gesture Karen made behind her head when she was in a standing position. For several weeks it remained incomprehensible to us. Then, one morning, after Karen had lost her uneasiness about playing on the floor, she lay there on her back shaking a rattling block. It fell from her hand, landing beside her ear. She moved her arm repeatedly back and forth between her shoulder and her head, trying to grasp the block which she could feel with her fingertips. Karen, with many months of experience on her back, was conducting a perfectly good search, a search based on past successes with fallen bottles and pacifiers.

We did not appreciate what we had seen until later during the same visit. After Karen had played with a musical rattle while lying on her back on the floor, it was taken from her and made

to sound beside her. Lured by the musical notes, she rolled over to her stomach. The rattle was then shaken in front of her. Karen accurately located the rattle by the sound, stretched her arm straight toward it, touched it with her fingertips, but couldn't quite take hold of it. Then a curious thing happened. Instead of reaching again to the spot where she had just encountered the rattle, Karen bent her arm and brought it back, to move her hand between shoulder and head. It was another attempt at a search, quite useless under the circumstances, yet she repeated it even when the rattle was again sounded and she had reached once more to touch it. In Karen's limited world there was one place where you could be certain of locating something. Supine, in her crib, fallen things came down behind her, toward her back. She had not yet caught on to the new relationship between her body, the floor, and the toy when she was prone. Although the floor was now beneath her stomach instead of her back, she still directed her search toward her back.

Perhaps then this particular behavior, waving her hand between shoulder and head, which seemed meaningless when Karen was upright, and which was obviously unadaptive when she was prone, had originated as an adaptive and successful search pattern, well-developed in the months she spent lying supine. As Karen was placed in new play situations, as she began to enjoy a variety of toys kept within easy reach in a playpen, as she experimented with sitting free, rolling, creeping, and pulling up, she quickly learned what worked and what didn't, and the sweeping arm gesture, as an inappropriate action, was never seen again.

However, changes in Karen's half-

closed upraised hands came more slowly. For almost half a year her grasp remained clumsy and immature. Her stiffly extended thumb was not used at all. Her fingers moved as a single unit, pressing against the palm when she wanted to hold something. Sometimes it seemed as if her fingers had never completely unfolded from their neonatal posture. At other times we wondered if her hands were permanently positioned to grasp the infant seat rails, turned back at the wrist, clenched in pantomime around the familiar bar.

We encouraged the mother to engage Karen's hands at midline with specific toys or hand play, but these suggestions often met with little or no success. The mother was unfamiliar with such infant play and seemed unwilling or unable to improvise hand games. We suggested patty-cake as a lap game her mother could teach to Karen. They could enjoy it together and it involved open hands. When we next came, we did see Karen patty-cake, but in her own way: clapping her fists together so that the backs of her folded fingers met, instead of her palms.

Changes were slow, but in time they did occur. Karen played happily in the playpen, but after awhile she had explored all its possibilities. She began to enjoy moving around the living room and from there she rapidly found her way through the entire house. She slept less and was more alert and vigorous. She was busy all the time she was awake, and her hands became increasingly involved in her activities. They were automatically used to help her get around, either for crawling, or in pulling up and balancing on furniture. In these situations, a fisted hand would be both uncomfortable and a hindrance. Karen

opened her fists. As more and more interesting things came within reach, she brought her hands together to manipulate and explore, to discover the qualities and details of each item. By 16 months, we seldom saw them aloof and apart.

Now Karen is 2. If the old hand posture occurs, it seems to be when she is uncertain or afraid—when there is a momentary confusion around her, when a stranger approaches, or when her mother scolds her sharply. Karen quiets and her hands briefly come up to shoulder height, or to her eyes. There is a pause, a moment to size up the new event. Then her hands relax and are lowered, and Karen sallies forth to join in whatever is going on.

The incomprehensible sweeping gesture has disappeared many months ago, and now the odd and awkward hand postures are almost a thing of the past. If Karen's development had not been altered, it is likely these behaviors would have persisted in their inutile forms. Seen several years in the future, they would have been difficult to understand—and even more difficult to change.

JOAN

Body-rocking is one of the most frequently mentioned repetitive behaviors of blind infants, and one which is never absent from descriptive listings of typical "blindisms." Joan, whom we have followed from early infancy, became a vigorous "rocker" in the latter half of her first year. We have been able to trace carefully in this child the initial onset of the rocking behavior, the conditions under which it would occur, and the characteristic pattern of the behavior until it disappeared.

We initially came to know Joan when she was 5 weeks old, following a diag-

nosis at our hospital of acute infantile glaucoma. The medical prognosis was that Joan would retain at best only a limited degree of light perception. Otherwise she was an intact, healthy, full-term baby. She has been followed by our project for almost the full 16 months of her life.

Joan was an illegitimate child in a loosely held together extended family of marginal socioeconomic status. Her mother was an affectively vague girl who seemed even younger than her 17 years. The household was fraught with many problems. Nevertheless, the mother and grandmother both became adequately involved with Joan and shared in the early care and feeding of the infant.

During the first half of Joan's life, her development was very uneven. On one hand, she was alert, responsive, smiled in response to family members at an early age, and accomplished all gross motor milestones (control of head lag, body control, independent sitting) well within our expectations for blind infants. However, her range of vocalizations was poor and her adaptive hand behavior seemed to lag.

It is important to note that pain was prevalent during Joan's early months. Interocular pressure, associated with the glaucoma, was difficult to control and required five separate surgical interventions before it was significantly modified when Joan was 6 months old. Intense crankiness and irritability characterized Joan during the months before the pressure was under control, and the only successful method of comforting her was through continuous rocking. Thus a major form of Joan's early contact with her important objects, a contact which provided some respite from pain

and displeasure, was through the tactile and kinesthetic experience of being rocked.

Joan's own self-initiated rocking began when her motor development had progressed to the point of steady, independent sitting at about 6 months of age. For the next half year, Joan was a vigorous "rocker." The rocking always took the same form—sustained, repetitive back and forth movements which involved the entire upper half of her torso. Her rocking reached a peak during the 6-to-9-month period, and slowly abated during the last few months of the first year. A final vestige of this behavior—lateral swaying while standing—emerged as Joan was attempting to take her first steps. This last form of rocking disappeared when she began to walk in a proficient and independent manner at about twelve and a half months. As we studied Joan's rocking during this 6-month period, we noted that it appeared in several different contexts, and we attempted to follow and understand its vicissitudes.

Initially, we noted that Joan's rocking was often associated with frustration. When her nap was overdue, when lunch was delayed, or when she was exposed to a fairly intense light (which was uncomfortable for her), she would often start to rock. Her back and forth movements were accompanied by signs of displeasure, such as frowning, crying, or whining. Again in our testing situations, where some degree of frustration is unavoidable, we could observe the point at which rocking would commence. For example, when a valued item was removed from her grasp in the course of a test series, she characteristically began to rock just as the toy was removed. When we offered her a new and strange

object to explore, this new experience would bring a troubled expression to her face and simultaneously rocking would begin. If, in her own play, she dropped a favorite toy by mistake, even as she tried to retrieve it, she would begin to rock.

Joan's rhythmic rocking was not self-absorbing or preoccupying, nor did it interfere with her interaction with people or objects. She continued to be outwardly directed and interested. She continued her search for the lost item or she continued to explore the new strange toy that was offered her, even as she rocked. It seemed to us that Joan had found her own particular means of reacting to frustration and anxiety. She was now able to actively make use of rocking as a solace, duplicating a previous comforting activity that had been experienced passively in the arms of the mother or grandmother.

There were other situations in which Joan was observed to rock that didn't seem to be associated with frustration. On several occasions during our visits, we noted that she began to rock when her mother moved her from one piece of furniture to another. Under these circumstances, as she rocked back and forth, her trunk came into frequent contact with the back of the furniture on which she sat. Her hands remained in her lap or at her side, not involved with exploring her new surroundings. At these times, signs of displeasure and anxiety were missing. It seemed that the rocking now had a different meaning to her. As we watched her, we began to feel that the repeated bouncing against the back of the chair or couch was providing Joan with information. We felt that through the rocking activity, Joan was attempting to become more aware of the limits of

her new surroundings. When the rocking occurred in this context, therefore, it seemed to serve as a form of orientation, providing her with increased knowledge of her external surroundings.

In the last quarter of the first year, as Joan became more mobile, rocking became less frequent. Its final form (lateral swaying while standing) occurred when Joan was at the brink of independent walking. She was clearly in a transitional phase of motor development. She was totally able to balance herself in a stand; she took small marching steps in place; she seemed intent on moving forward, but couldn't quite push herself to do it. As one observed her struggle with this important transitional step, one could note a generalized tension mounting throughout her musculature. On the edge of walking, but not quite able to move forward, she would experience a tension which could not be released in the wished for action (walking). Rocking and swaying seemed to serve the purpose of intermediate discharge of these accumulated energies in such a way as to facilitate her progress through this difficult period. As a coordinated pattern of walking began to emerge, the swaying activity became less frequent. By the time Joan had achieved a smooth independent walk, and the degree of autonomy that went with it, the rocking behavior disappeared altogether.

Rocking seemed to serve varying functions for Joan during the second half of her first year. It served to reduce tension during periods of stress and anxiety; it duplicated a comforting rhythmic actively experienced through the earliest months of infancy; it helped her orient herself to new surroundings, and became an adaptive means of discharge through a difficult transitional stage of develop-

ment. In this child, who successfully negotiated these milestones of development, it seemed to have little if any pathological implication, but rather to serve helpful and adaptive functions in her progress toward independence and autonomy.

RICHIE

Our final case history is that of a well-stimulated, intelligent child who, toward the end of his first year, became absorbed in a series of repetitive, stereotyped activities that increasingly usurped his total waking hours.

Richie's eye condition was recognizable at birth and was diagnosed as resorption of the vitreous humour at the time of the examination at University of Michigan Medical Center when he was 3 weeks old. He has been followed by our project since this initial visit to the University Hospital. There has never been any possibility of vision, even of the most limited light perception. This child is totally blind.

Richie was a full-term baby, alert and active, and apart from the blindness, a healthy, well-formed infant. He is the only child of a couple in their late twenties. His parents are well-established financially and felt they were in a position to offer Richie every opportunity to develop his potential.

Richie's development through the first months of life was excellent, paralleling norms for sighted children in almost every respect. He was a lively, interested, responsive baby. A first tentative smile was noted at 23 days in response to mother's talking to him. Gross motor development seemed to progress with ease, proceeding to a complete independent sitting position at 7½ months.

Particularly noteworthy was Richie's

superior hand development and his interested exploration of new toys and objects. He was also an athletic little boy and seemed to enjoy his body activity. A cradle gym over his crib provided him with a great deal of active pleasure. He appeared to manage his body well. He was skillful in the use of his feet in combination with his hands in complicated operations such as retrieving a play object that had rolled away from him. He was among the youngest of our children to achieve a coordinated reach on sound cue alone.

The first signs of difficulty were very subtle ones. While Richie sat firmly at 7 months and would engage in play with toys for quite extended periods of time in this position, he seemed to do so with less pleasure and variety than had characterized his play activity in former months. Moreover, after he had demonstrated his ability to sit independently for something like two weeks, his mother suddenly became anxious about the possibility of his falling backward, and insisted on placing a pillow behind him on the floor. At the same time, both parents began to express concern that he was not progressing as fast as he should, especially in the area of motor development—e.g. creeping, standing.

All our efforts to reassure them were to no avail. During the next few weeks, we became increasingly aware that the anxiety of the parents over the child's progress was pushing them to react in two opposing ways. On the one hand there was an increasing overprotectiveness and, at the same time, an anxious pushing forward toward greater motor achievements—e.g. putting him through the motions of a crawl or walk.

Between 9 months and a year, there was a dramatic change in his overall

behavior. Motor development came to a complete standstill and a marked resistance to gross motor activity became apparent. Attempts to encourage such activity by the parents (which we were unable to reverse) met with what can only be described as flat refusal. He began to demonstrate a persistent desire to lie on his back in preference to any other position. He was observed to be increasingly melancholy and irritable and only responded with open pleasure to games that involved close bodily contact with either father or mother. These games were always accompanied by a high level of excitement. With father, this was most often associated with the kind of excitement that verges on fear—i.e. when father would toss him in the air or swing him vigorously upside down. With mother, it had more often the quality of erotic excitement—i.e. energetic tickling games, or kissing and nuzzling games. With either parent, there was an intense enjoyment of having his body passively put through rapid activity, such as a fast hand-clap or leg-pumping, in which the activity was completely initiated and controlled by the parents.

At the same time, his play with toys became increasingly constricted and shortly was almost completely limited to prolonged periods of shaking two rattles in parallel position with the hands at shoulder height. Otherwise toys were most often rejected altogether. Over the next few months, in the first quarter of his second year, there was an increasing involvement in a whole series of repetitive rhythmic activities. When he was in a sitting position, these included hand-twisting at shoulder height, rapid hand-clapping, trunk rotation, and an almost continuous turning of the head from side to side (as in an exaggerated "no"

gesture). When he was on his back, the activity was typically an energetic bilaterally synchronized kicking and hand-flapping combined with a kind of "body-bumping" which was accompanied by excited squeals and laughter. There was an increase in head-knocking, first with his thumb, then with his fist.

These were not transitory behaviors. They persisted with little change throughout his second year. Attempts to interrupt him when he was engrossed in these activities were met with violent resistance and angry crying and the child returned to them as soon as he was allowed to. Constructive play with toys, as well as progress in motor development, remained at a standstill. His principal activity with toys was to throw them away with great energy, scarcely interrupting his repetitive rhythmic activity.

Interestingly enough, although this child was held and rocked for hours on end in his first year, and although the only moving infant seat he has ever made any extended use of is a small rocking chair, he has never included in his repetitive activity a body-rocking of the sort that duplicates the motion of a rocking chair. Moreover, in this chair, which is the only place where he will engage in self-initiated motor activity which does not seem bizarre or stereotyped, he has always seemed most in touch with the world. Here he will engage in talk without the ceaseless head-swinging and hand-clapping. Here he will peacefully sit and rock and listen to records, or to conversation around him; here he will occasionally accept and explore a toy. Here he has been observed to make his first, and among his only, spontaneous attempts to move from sit to stand. However, he only

tolerates sitting there for short periods of time.

Because of our concerns over Richie's developmental problems, we arranged for a second neurological examination at 16 months of age. The medical opinion, confirming the original report from early infancy, was that Richie was neurologically intact and they could find no medical basis for his difficulties.

Throughout the year and a half in which these repetitive, rhythmical activities have dominated the waking life of this child, there have been some areas of development which held up relatively well. Most encouraging, perhaps, is the fact that language development seems to progress at age-adequate levels. There have also been no major disruptions in eating and sleeping patterns. He feeds himself (with fingers), enjoys a wide variety of foods, and asks for favorite foods by name. There is an increasing use of full sentences.

While there seems to be evidence of slow gains and occasional progress toward voluntary attempts to stand and walk, etc., these are subject to severe setbacks whenever there is some interruption of the daily pattern in the child's life—as, for example, when he is ill. It is notable that this child had severe illnesses more frequently than any other child in our sample, although these have never been other than those illnesses to which infants are regularly subjected—colds, intestinal upsets, and the like.

During this period and throughout his second year, we attempted to shift our relationship with the family to focus on an individual counseling relationship with the parents, providing a separate male worker for the father. We hoped to help the parents deal with the deeper anxieties and disappointments in relation

to the child which we felt were the real source of the child's developmental crisis. These efforts have met with little more success than our initial attempts to reduce the parents' concerns over the child's rate of motor development at 8 and 9 months. There was an increasing lack of synchrony between the child's actual activity and the parents' perception of it. While they often followed specific suggestions to the letter, there seemed to be no understanding of the underlying spirit, nor could we see any evidence that we had been able to penetrate the depths of their anxiety in such a way as to effect their interaction with the child.

Richie's intense absorption in this repetitive, stereotyped rhythmic activity has not served an adaptive function for him, but increasingly moves in a pathological direction. His absorption in these behaviors has led to a progressive interference and regression of serious proportion in both psychological and physical development.

SUMMARY AND CONCLUSIONS

The preceding cases describe three distinct behavioral syndromes, each of which bears some relationship to the kind of behavior associated with the term "blindism." In each case, the behavioral pattern discussed is directly related to the individual child's developmental vicissitudes and particular life situation. While blindness imposes a primary condition of deprivation on these children, the behavioral patterns discussed seem to emerge from specific circumstances of the children and to parallel in many ways the kinds of behaviors that occur in sighted children in similar life situations.⁵

The examples cited here fall into three

categories: (1) conditions of understimulation and experiential deprivation, (2) problems of adaptation, learning, and adjustment at transitional stages of development, and (3) pathological reactions to disruption in the parent-child relationship.

Karen's peculiar, awkward hand-posturing and sudden odd gestures disappeared when she was given adequate stimulation, education in the use of her hands, and opportunities that made search for toys possible and rewarding. Karen's hand behavior at the time of our initial visits were similar to the awkward, peculiar fingering motions of severely deprived, institutionalized children^{1, 17, 18} where equally impoverished surroundings and opportunities to learn to use their hands adaptively has led to similar distortions. Karen's home was not a richly stimulating one for any child, but the condition of blindness made Karen's life experience in this spare household one that resembles that of a child in a completely barren, institutional environment.

For Joan, the use of self-initiated rocking under situations of stress, strangeness, and momentary plateaus in development disappears as she is helped to overcome developmental obstacles, or matures and advances successfully to the next step of a developmental sequence. Rocking of the kind in which Joan indulged is not unusual in normal sighted children in similar circumstances.^{2, 10, 14} Persistent and prolonged rocking has been described in the case histories of severely disturbed or deprived sighted children^{1, 9, 17} as well as in numerous accounts of blind children.^{13, 16} Without a complete history of antecedent events, the original connections with stress and adaptational problems are often no longer visible.

In Richie's case, blindness seems to have imposed a greater obstacle to the development of coping mechanisms or defensive adaptations to the disruption in the parent-child relationship than might be the case with a sighted child. While there are still differences between this child's psychological state and that of an autistic or psychotic child, particularly in that he seems to maintain personal relationships and reality ties to his environment, nevertheless his firm entrenchment in these stereotyped, ritualistic, repetitive activities bears a frightening resemblance to those observed in severely disturbed children^{1, 11, 15} and clearly has had an adverse effect on every aspect of his development during his second year.

We cannot predict, at this time, the effects of further life experience on the future development of the three children discussed, nor can we make generalizations from our three cases to the total population of blind children, but we feel that these cases serve to illustrate something of the complexity of the problem of the origin and meaning of so-called "blindisms."

A further consideration of these behavior patterns will be dealt with in a forthcoming paper based on an extensive exploration of clinical and developmental data from the life histories of ten blind infants. It is hoped that this material will suggest directions for further research related to such behaviors, in a variety of childhood situations, and will facilitate the development of techniques for alleviating or averting these disturbing and disruptive activities in the growth and development of children with sensory deficits.

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DELIVERY OF SERVICES

MENTAL HEALTH AND THE URBAN CRISIS

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The current urban crisis is profoundly affecting mental health workers and institutions. Community consultation, emergency treatment, group therapy, and nonprofessional activities are growing in importance. Yet mental health institutions and programs are under attack from various factions in both the community and the profession—proving the new involvement both a challenge and a danger.

Simmering urban problems have exploded into racial riots during the last few summers, focusing the nation's attention on the crisis affecting almost all our social institutions: education, health care, law enforcement, transportation. Reports like the following are, unfortunately, not a novelty:

For a week there was storm and stress. Cars were assailed, men attacked, policemen struggled with, tracks torn up, and shots fired, until at last street fights and mob movements became frequent, and the city was invested with militia.²

Does this describe Chicago during the last Democratic convention or perhaps

Washington, D. C. after the assassination of Martin Luther King? Actually, this quotation comes from Theodore Dreiser's *Sister Carrie*, written at the turn of the century. When facing our present urban crisis, it helps to keep a historical perspective. Riots are not new on the American scene. I believe it was Rap Brown who said that "violence is as American as apple pie." We easily forget the violent episodes, such as this one described by Dreiser, which accompanied the trade union movement. We need reminding of the bloody anti-Catholic riots in the 1830's and the anti-drafts riots during the Civil War in

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which over a thousand people were killed. Even racial tension, one of our major concerns today, erupted in savage riots as long ago as World War I.

This then is not the first occurrence of rioting in our country nor is this the first *urban* crisis in our history. Similar crises developed in our cities during and after the Civil War when Irish and German immigrants congregated in large cities such as Boston and New York. Social upheaval, including violence and riots, accentuated the rapid population movements. Again, just before World War I, immigrating Italians and Jews from eastern Europe caused changes in the existing city patterns.

Historical and intellectual perspectives provide slight consolation, however. We are living in *this* crisis. Our social agencies have to deal with the current struggles between black and white, between suburb and inner city, between prosperous and poor. The President's Commission on Civil Disorders, the Kerner Commission, has warned of the constantly widening schism rapidly splitting our nation into two societies: black and white.

Psychiatrists are aware that outbursts of hostility and anger occur during periods of change in individuals, families, and groups. Clinical experience makes us aware that eruptions of feeling are important indications of changes in personality functioning and group structure, and are often indicative of transitions to new growth and adaptations. While we do not value hostility and violence for themselves, clinical experience permits viewing such feelings and behavior as part of the overall spectrum of human adaptation. At the same time, clinicians are well aware of how maladaptive it can be if reorganization and new adapta-

tion does not follow periods of abreaction and conflict. Without changes in personality functioning, the abreactive and conflictful expression of such feelings repeats itself in a maladapted cycle.

To quote Sammy Davis, Jr., "It's hell to grow up in a land of Gary Coopers and then find out you are one of the Indians." Dr. Garrett O'Connor,⁷ a psychiatrist at Johns Hopkins University, summarized the situation well:

Segments of the Negro population are incensed by the lack of white response to their legitimate pleas for equality and, in their impotent frustration, resort to rioting. Segments of the white population, in turn, become outraged at the "lawlessness" of the "ungrateful" Negro. The stereotypes are up and the battle is on. The lower-class white population's anger and hatred of the Negro is based on fear, fear of his ascendancy over them.

How is this crisis affecting the social workers, psychiatrists, and psychologists who are the mental health professionals? Profoundly! It is accelerating the trend toward social psychiatry and community mental health. It is accelerating trends toward brief therapy, consultation, family and group therapy, and community action. It is shifting the balance of training programs. More significantly, it promises to force major changes in mental health practices and go against current concepts of professional activities and aims. Furthermore, there is danger that in the increasing polarization of American society, the mental health agencies, like other liberal institutions in our society, will be caught between right and left, revolution and reaction.

My thesis is that there is both danger and opportunity in the current crisis. Our integrity may be questioned and our professionalism undermined. To elaborate upon this thesis, I believe it is necessary to look in detail at one community

mental health center's experience with urban problems.

DEVELOPMENTS IN CONNECTICUT

The Connecticut Mental Health Center and its program characterize the new community mental health centers which are our present hope in dealing with the nation's mental health problems in general, and its urban problems in particular. The efforts to cope with the problems of New Haven are not just the struggles of a particular mental health center in a particular city. Rather, they typify the exploratory approach needed by any community mental health center to deal with the urban problems in any city.

In developing its program, the Connecticut Mental Health Center has a dual aspect: it is both a major community mental health facility for the greater New Haven area, and a university center for training and research whose responsibilities are world wide.⁸

Four Connecticut Mental Health Center programs have directly involved the center in the urban crisis in New Haven: the Hill-West Haven Mental Health Project; the Emergency Treatment Unit, which provides crisis intervention; consultation with the public school system, particularly our experience at Hillhouse High School; and sensitivity meetings for police and community to alleviate antagonisms. These four are examples of the range of direct and indirect clinical and consultative services which community mental health centers are providing.

THE HILL-WEST HAVEN PROJECT

My first example is the Hill-West Haven Project, a catchment area of

75,000 people. The Hill neighborhood of New Haven is a typical inner city ghetto, with characteristic social unrest and high rates of mental illness accompanied by pervasive unemployment, substandard housing, poor schools, and racial discrimination. This neighborhood is in the midst of marked social transition; relatively large numbers of blacks and Puerto Ricans have moved in following the exodus of Italian, Irish, and Jewish groups to the suburbs. The neighborhood was recently selected for a Model Cities program and was also, significantly, where the riot in New Haven broke out in August 1967. Yale Medical School is making major community health commitments to the Hill, and the mental health program is part of this commitment.

The Hill-West Haven Project has developed experience with techniques such as consultation with the schools, leadership training for neighborhood people, training for residents and field workers, and development of a welfare rights organization. These activities supplement the usual community mental health services. With more thorough knowledge of the neighborhood, however, the depth of the needs and the extent of the social problems appear overwhelming. It became clear that direct clinical service can only meet a fraction of the need. Consequently, increasing efforts are now being devoted to preventive and community work.

In West Haven, the Hill-West Haven staff participated with other agencies in the formation of a community services committee, which was needed to develop comprehensive plans not only for mental health services but for all health services, for educational improvement, and for

community organization. In the Hill neighborhood, one of the worst ghettos in New Haven, we have become actively involved with the department of pediatrics of Yale Medical School to develop a Hill Child Health Center, funded by a grant from the U. S. Children's Bureau. It is of interest that when the Children's Bureau recently cut the promised budget for the second year of the Child Health Center, it was the community reaction which spurred a joint effort by the city administration, neighborhood residents, and the medical school leadership to actually go to Washington and fight vigorously for restoration of the cut funds.

After two years of experience in the Hill-West Haven catchment area, I am increasingly impressed by the far-reaching impact of this approach as compared to clinical services which are not specifically geared to the individual neighborhood and community. Psychiatrists frequently see a woman with suicidal depression and study her individual psychodynamics and family relations, but a whole new dimension is added when she is seen in her neighborhood context against the background of ethnic struggles, urban renewal, and community change.

Experience in this neighborhood has also brought greater awareness of the gulf which often exists between professional and client in their background and attitudes. The staff has become sensitive to the community's mistrust and ambivalence toward the mental health professions. There have been various past experiences, similar to that with the Children's Bureau, when expectations raised by grants and innovative programs were dashed by failure to deliver the promised services.

EMERGENCY TREATMENT UNIT

One of the first services opened at the Connecticut Mental Health Center was an Emergency Treatment Unit whose stated goal is prevention of chronic hospitalization through intensive crisis-oriented care. To ensure this crisis approach, an arbitrary limit of three days was placed on the duration of hospitalization, with a 30-day period for outpatient followup. The major proportion of care is delivered by nurses, aides, and nonprofessionals who are taught and advised by a team consisting of social workers, psychiatrists, and psychologists.

Experience over two years indicates that this approach is successful. Over 40% of the patients admitted to the unit over the period of a year are psychotic, an equal number are involved in suicidal activities, and a large number of patients have drug problems. Despite these patient characteristics, 80% can be returned to their communities after three to five days of intensive treatment. In the 30 days following their discharge, over 80% can still be maintained in the community.

We have found, however, that the crisis model as originally described by the work of Lindemann⁵ and Caplan¹ has only a limited generalizability for an urban population. Their theory of crisis intervention envisioned an otherwise normal individual or family temporarily overwhelmed by external stresses beyond their capacity to cope. Our experience in an urban area indicates, however, that the majority of our patients have chronic social and psychopathological disabilities. The current episode represents only the latest in a series of crises which recur as a pattern of life in ghetto families with their multiple social, economic, and psychological handicaps. Patients treated

in the Emergency Treatment Unit are now being compared to those sent to the state institution, Connecticut Valley Hospital. We are also doing a followup study to determine the long-term impact of treatment here, particularly inquiring into whether our emergency patients are hospitalized later elsewhere.

CONSULTATION WITH THE PUBLIC SCHOOL SYSTEM

The public school system is under enormous stress. Experiences in New Haven have been a microcosm of those which have erupted so disastrously in New York and other cities. National developments were brought sharply into focus at Hillhouse High School, one of three senior high schools in New Haven, where riots erupted in the winter of 1967-68. Hillhouse High School is a modern building with a reputation for academic excellence of many years standing. In 1967 the board of education reassigned many of the Jewish and Italian students to the other high schools in an effort to establish a better racial balance. With the number of black students increased to over 60% the character and goals of the school population altered considerably, but the administration and guidance counselors were still oriented toward the college-bound student, now in the minority. The guidance counselors were faced with a predominantly different type of student and predominantly different types of problems such as drug abuse, illegitimacy, and anti-intellectualism.

Two members of the CMHC staff, a psychiatrist and the director of social work, were asked to meet with the counselors weekly as consultants about individual cases. This developed into a group forum where the counselors could

express the frustrations and anxieties caused by the school's changed composition.⁹ The stresses in the school did not wait for this leisurely professional pace, however. In December 1967 a white boy punched a Negro girl during a flag ceremony and pent-up anger burst out in open conflict between black and white students, ending up with general destruction of school property.

Despite a general acknowledgment of some legitimate grievances, parent-administration discussions in large groups were made impossible at the time by fear, suspicion, and anger. The mental health center was asked to help organize small, multiracial discussion groups for parents to air their feelings and agree on goals and priorities with the guidance of a neutral consultant who had no official affiliation with the school. The effectiveness of these meetings was demonstrated as these groups later coalesced into an effective organization of parents which negotiated with the administration, teacher groups, and students over the following months to bring about a gradual reduction of the riot atmosphere.

That spring a new principal, himself a black, was appointed at Hillhouse High School and although tensions remain high, there were encouraging signs last year that the crisis had shifted to a more hopeful phase with active negotiation and participation by the community in the affairs of the school.

This experience demonstrated the value of small group techniques, particularly in helping parents to organize in order to express their needs and wishes to the appropriate groups, whether school administration, teachers, or students. We also learned the importance of being familiar with the specific social system of the school through prior con-

sultation. Consultation is emerging as one of the main links between the mental health profession and key community institutions such as the schools and welfare agencies.

POLICE-COMMUNITY SENSITIVITY GROUPS

My fourth example is our participation in sensitivity groups with police and community residents. In the electric atmosphere following the death of Martin Luther King in the spring of 1968, protests came from the Hill ghetto about police repressiveness. In response, New Haven's newly appointed chief of police expressed his willingness to have policemen participate in sensitivity groups with black residents to promote communication and better understanding. Staff from the CMHC played an active role, helping organize the sensitivity groups, providing consultation and some of the group leadership.

One source of conflict was the community's resentment of police wearing uniforms complete with guns. The residents reacted heatedly not only to the police being armed but also to their having the power to arrest participants when they "tell it like it is." The situation came to a head when one resident was almost arrested on a charge of vilifying an officer; the policeman claimed that he was "physically intimidated and verbally abused." The groups were dispersed with a good deal of ill feeling on both sides. There is considerable disagreement as to the responsibility for this outcome, with as many versions as there were participants. Charges of sabotage were made by both sides, and even the exact sequence leading up to the disruption is still not clear.

Feelings continue to run high among

the police and certain militant groups about the value of the sensitivity group experience. However, many citizens and agencies have requested that these exercises be resumed. We feel that we learned a great deal and hope that the climate will soon be ripe for a new attempt by the police and the community. This experience exemplifies the difficulties of professional and welfare agency people caught in the crossfire between the establishment and the insurgents, and regarded with suspicion by both.

PLANS FOR THE FUTURE

The dialogue between various groups within the greater New Haven community has accelerated and intensified over the past two years. It was originally spurred by the local riots in the summer of 1967 which shocked our social institutions, governmental agencies, Yale University, and the medical center into awareness of the need for action. A new organization within the black community, the Black Coalition, emerged as the public spokesman for New Haven's blacks and gave local meaning to "Black Power." While the police and the public schools have been most involved in the confrontation between the black community and established public institutions, health and mental health agencies can expect increased pressure for improved services. There will be greater demand for better communication between professional and client and for community participation in decision making, both in policy formation and the direct day to day operation. We are aware that some of the CMHC's present programs and practices need improvement, and a description of them will show the types of changes and problems many of our social agencies are involved

with. Our experiences are not unique. Rather, they illustrate the dilemmas and conflicts all mental health and social agencies are facing.

1. There is need for greater community participation in advisory boards and decision-making bodies of mental health centers. There are limitations in the present advisory boards, traditionally composed of high status professionals, representatives of the upper middle class, and the business community. This traditional composition legitimizes the institution in the eyes of the dominant establishment and also provides effective links with other agencies. It fails, however, to provide a mechanism for communication with neighborhood groups, particularly the inner city ghettos, nor does it provide a useful feedback of information from the recipients of its services. CMHC is developing a neighborhood advisory group composed of residents of the Hill and another advisory group for the city of West Haven. In addition, there is an obvious need to add representatives from the black and Puerto Rican communities to the formal advisory board.

2. Another problem area is the hiring of personnel. The CMHC has some prominent blacks on the professional staff, particularly the director of nursing, personnel officer, assistant director of social work, and the director of the Hill-West Haven Project, but there are not enough at the middle levels of professional care. Review of the staff shows that, as happens all too commonly, the majority of blacks and Puerto Ricans are concentrated in the nonprofessional, maintenance, and less skilled clerical positions. Because the nonprofessional staff are generally state employees, we are restricted by the state civil service regulations which require such things as

previous employment, written examinations, high school diploma, and the absence of police records. All of these requirements are barriers to hiring ghetto residents. It is ironic that the civil service procedures, which were established a few decades ago to promote equality and guarantee fair hiring practices, have become a source of de facto segregation. Changes in hiring practices and civil service regulations are clearly called for along with work-study programs to provide meaningful experience and training along new career lines.

3. The community mental health center's involvement with community activities and social issues causes serious concern to many of our colleagues. Federal regulations state that these centers must provide comprehensive services to all persons in the local community. A unique feature of the federally sponsored program is the regulation that community mental health centers serve what is called a "catchment area," which, according to the NIMH criteria, is a region surrounding the center and encompassing 70,000 to 200,000 people. This requirement is based on the assumption that by defining a population area living in an ecologic zone, the mental health services can be better geared to the specific needs of the neighborhood and better articulated with other agencies. The demand for equality for all people regardless of color, race, or creed is a familiar one. Another prejudice which has not been so widely discussed, however, is the prejudice against those not well-scrubbed and well-spoken. Even mental health professionals are guilty, with the result that these "undesirables" are often screened out under the guise of not being "good teaching cases" or patients "suitable" for a particular research project.

Now the community mental health center is required to help *all* those in need within its zone, including the drug addict and alcoholic, who have been avoided in the past on the pretext that these conditions are chronic and untreatable. Professional discomfort with the unkempt, the ill-mannered, and the abusive is very apparent in emergency rooms of general hospitals and we see it in clinics at many mental health centers. Since a neighborhood family physician is rare in the ghetto, residents seldom have patterns of regular health care. As a result, the emergency room becomes the institutional family doctor for the poor. Yet there are continual complaints about the emergency room being crowded and understaffed and people being treated callously. Unfortunately, these complaints are true. A Yale sociologist, August Hollingshead,³ and a pediatrician, Dr. Raymond Duff, in their recent book *Sickness and Society* document the variation in care provided to the different social classes. Ghetto residents, already bruised by the stresses of poverty and tenement life, are treated perfunctorily and coolly. Upper-class patients receive far more care and courtesy.

4. A problem of professional technique arises as a corollary to this reluctance to treat all types of patients. The clinical staff has become more aware of the difficulties arising from the present emphasis on verbal understanding. Having developed a strong professional value around techniques such as individual psychotherapy and understanding of individual psychodynamics, there is a tendency to seek out the articulate and intelligent, the so-called "good teaching case." In another study a decade ago, Hollingshead⁴ and Dr. Fredrick Redlich, a psychiatrist, reported that much of our

mental health care is social-class linked, particularly because of the emphasis on verbal skills and potentiality for insight development. Even after expanding treatment to include drugs and group therapies, many of our techniques are still only appropriate for white working class and lower middle class clients. We must show greater flexibility. We need to adapt present techniques to meet the needs of our actual patient population while constantly exploring for effective new approaches. The alternative is further neglect of a large and desperate group. If we do not adapt our techniques and clinical practices, we run the danger of becoming ossified; professionals whose only clients are those who are white, middle class, verbal, and conforming.

5. The professional's view of his world creates a great disparity in priorities between the neighborhood residents and the professionals who work with them. The ghetto population feels frustrated by the professional's lack of interest in the areas to which they give the most emphasis: drug addiction, alcoholism, and child care. They have less interest in long-term individual or group psychotherapy and see the emphasis of highly trained mental health professionals on such procedures as irrelevant to their immediate needs. This difference in interests has been remedied to some extent by the establishment of a major drug addiction program. Two facilities are planned to begin operation this fall. There will be a residential treatment facility staffed by specially trained, former addicts. And an outpatient clinic will offer a variety of services, including a methadone maintenance program, psychotherapy, a preventive program, and epidemiological studies. In addition, CMHC plans to use its ex-

addicts as workers in the community to encourage addicts to come to the Center for treatment. Plans are being made which will ease the community concern about child care facilities. A new Child Study Center will be constructed in the medical center complex whose staff will work in close collaboration with the CMHC. This facility will be primarily for outpatient care but there will be some beds for diagnosis and hospitalization of acute cases. There will also be a small inpatient facility at the CMHC. These plans will not become an actuality until 1971 at the earliest, and possibly not until 1973. In the meantime, serious needs for child care services remain unmet. The third main ghetto concern, alcoholism, has been left by the wayside. It remains a vast neglected area, with few current plans for new programs or approaches.

CONCLUSION

In conclusion, I would like to elaborate on the thesis which I started earlier. Just as this urban crisis creates opportunities for mental health professionals to deepen our practice and broaden our skills, it also presents dangers ahead. Like most mental health programs, that of the community mental health center attempts to be rational, aggressive, and liberal. This is in the best tradition of our professions and universities in American life. In the current crisis, however, this liberal position is in danger of being attacked by both the forces of reaction and revolution. The revolutionaries and radicals in our society, including the black militants and white youths, are critical of the mental health profession. They see mental

health professionals as bound to the establishment, integral parts of the repressive institutions which demand conformity in order to perpetuate the status quo. Their distrust of our therapeutic efforts makes them hesitant to seek our services. On the other hand, the forces of reaction also distrust us, having identified us as "do gooders," "socialistic," permissive, and tending to apologize for violence.

The mental health professionals are in danger of being caught in the middle as the current crisis increases the conflict between the polarizing sections of society. The challenge before us is to change rapidly enough to meet the needs while retaining our professional values and integrity as we assist the forces who work to resolve the crisis which is upon us.

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OUR PLACE: DESIGN FOR A DAY PROGRAM

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Faced with the challenge of community mental health, those concerned must develop relevant and innovative programs. One such attempt, a day program operating as a therapeutic community under a nonmedical model of treatment and utilizing multiple interlocking group therapy exclusively, is discussed in this paper. Particular emphasis is placed on the importance of non-professional and ex-patient staff members.

Although in the past few years the number of day programs in the United States has grown quite considerably, the number of persons attending these programs has grown not at all.²⁰ This unusual and disturbing circumstance has prompted the medical director of the American Psychiatric Association to classify the conceptualization of the day program as one of the two most pressing problems facing the burgeoning community mental health center movement.¹ Legislative requirements governing the operations of such centers are largely responsible for the multiplication of day programs. Each new center must offer partial hospitalization services, and more than 300 centers have come into existence since 1963. Few community mental health centers previously offered

this service, and half are introducing it into areas in which it was previously unknown.⁵⁷ Yet the total number of persons utilizing such facilities remains unchanged.

Why is this so? From a historical viewpoint, it has been said,⁴⁶ the community mental health center movement represents an extension of the benefits of American society similar to that experienced under the New Deal. However, at that time full benefits were extended only to the middle class, which was actively seeking them. The current phase of extension is meant to include finally within the mainstream of our national life the lower classes who, out of apathy, hopelessness, a lack of shared values, or the antipathy of the middle and upper classes have never sought to

be included. Many persons interested in psychiatry, including Freud, have pointed out that the differing conditions of proletarian life imply the necessity for modification of techniques which were evolved to meet the needs of an exclusively bourgeois population.^{2, 5, 18, 28, 30, 45, 50} The cogency of these arguments cannot be denied. Surely a rigid adherence to standard forms of treatment when applied to new populations is part of the reason for our lack of success.

It must be recognized, however, that this line of argument contains a crucial but hidden assumption. It is that our existing methods of treatment, when applied to the appropriate middle-class population, are wholly adequate and gratifyingly successful. Clinical and empirical evidence supporting this assumption is, to say the very least, lacking. Indeed, part of the growing disenchantment with mental health services, even among the middle classes, may be related to this conspicuous lack of palpable success. Recent experiences with day programs may represent only a special case of a very general problem. Apologetically modifying existing techniques ("... to alloy the pure gold of analysis..."¹⁸) for the benefit of the lesser breeds may be missing the point. It may be the better part of wisdom to begin to think in terms of thoroughgoing and deep-cutting innovation all round. Unless mental health services in general become more meaningful, the fate of the new day programs awaits us all. To be ignored as irrelevant is far more painful than to have failed.

The purpose of this paper is to present the basic conceptual framework of the day program at the Temple University Community Mental Health Center. Since the program has been described in con-

siderable detail elsewhere,^{4, 20, 86} the emphasis here will be upon theory rather than practice. However, it is worth noting that the program opened in September of 1967 and has dealt with a predominantly lower-class Negro population. There have also been a number of admissions of white and/or middle-class persons. Average daily attendance has ranged between 25 and 30 persons (the latter figure being the current limit of the program's capacity), making it one of the larger programs in the country.²⁰

Four primary ideas form the conceptual building blocks of the program. The ideas themselves are not new; rather, it is their combination within one program and the idiosyncratic constructions placed upon the basic ideas which lend the program its uniqueness. They include: (1) the idea of a day hospital; (2) the idea of a therapeutic community; (3) the idea of multiple interlocking group therapy; and (4) the idea of a nonmedical therapeutic setting. The delineating of these ideas may be of some service in developing the new therapeutic modalities which must come. The further issues of the efficacy and feasibility of the program, while highly relevant, must await more detailed consideration elsewhere. The present communication will deal only with the program's basic concepts.

THE IDEA OF A DAY HOSPITAL

Moscow was the site of what was probably the first day hospital program, as long ago as 1932⁵⁶; and it may well be that countries under the influence of Soviet psychiatry have made the most imaginative use of this modality.⁸⁰ Canada, England, and the United States have also had a wide experience with

day hospitals. Beyond their common general characteristic of dealing with the people who come to them on an eight-hour a day and usually a five-day a week basis, there are many interesting aspects of these programs which have been adequately dealt with in summary articles.^{58, 60}

A singular variety of claims has been pressed for these programs. For example, they are said to be more economical, both in terms of professional time and in monetary terms. They are said to provide a smoother transition between inpatient service and outpatient service; indeed, the day program is frequently conceptualized as a transitional service entirely, rather than as a service in its own right. Day programs are also said to prevent the exclusion of the patient from the life of his family and his community. In the heat of the initial enthusiasm over this form of treatment, the claim was frequently made that it could entirely replace inpatient therapy and make wards with beds obsolete. In a recent article this was referred to as "the great hope of the day center."²⁵

If this was indeed "the great hope," it was sadly misplaced. While it is true that a considerable number of the patients ordinarily cared for in an inpatient setting can be handled in a day hospital,⁵⁹ rather heroic measures on the part of the staff and the patient's family are frequently required, and the results are no better.⁵⁵ Hospitalization is *not* obsolete and, like any other treatment modality, it can intelligently and judiciously be used as a part of the overall therapeutic design for a given patient.³⁹

There may be some truth in all of the claims advanced, but they seem to fall short of the mark. Though it may occasionally serve as a transitional or

stop-gap facility, the major advantages of a day program do not become apparent until it is viewed as a modality in its own right. It can be so viewed because of its unique advantage, which is that it provides a more nearly equal division of time for the population it serves between a therapeutic environment and the natural environment.

In outpatient treatment, the individual is so totally immersed in his natural environment that it is difficult to see how 50 minutes per week in a therapeutic setting could possibly make the slightest difference. In the inpatient setting the individual is totally cut off from his natural environment; therefore, the behavior observed must needs be highly artificial. Only in the setting of a day program (or other partial hospitalization program) is significant time spent in both the natural and the therapeutic environments. Such programs may therefore afford a much more realistic observational and interventional basis than any other. There is an unusual opportunity to put what is learned in the therapeutic setting into service in the natural environment, and thereby to gain almost instantaneous feedback leading to more effective therapeutic strategies. The involvement of significant others in the natural environment is also greatly facilitated. In brief, the day program structure may provide the optimum opportunity to appreciate the diagnostic and therapeutic importance of the resonance between the individual and his surround, a resonance which is perhaps the critical factor in community psychiatry.⁴⁴

THE IDEA OF A THERAPEUTIC COMMUNITY

In a certain sense, the notion of a therapeutic community was the central

concern of Plato's *Republic* and Aristotle's *Politics*. Even in the specific area of medicine, the Greeks of the Golden Age bear off the palm. The Temples of the Aesclepiades were overtly designed as therapeutic communities. Many of the same principles were evident in the "moral treatment" of the insane associated particularly with the Tukes at the York Retreat in England but prevalent even in the United States during the latter part of the eighteenth and early nineteenth centuries.^{43, 48} Largely put into its present psychiatric form by the British during World War II, the general ideas of the therapeutic community have been summarized in review articles.^{12, 19, 27-29, 31, 48, 49}

Although the combination of a day hospital and a therapeutic community is infrequently discussed (but see reference #7), most day hospital programs are represented by their directors as being therapeutic communities.²⁰ Yet inspection of their programs leaves some room for question. This dilemma may be resolved through a distinction made by Clark between two aspects of the idea:

The first is a general therapeutic community approach; this is a way of looking at the life of patients in any psychiatric institution and restructuring their lives. The second is the therapeutic community proper, a small face-to-face intensive treatment facility with extensive social restructuring.¹²

To be more explicit, the constituents of the general therapeutic community have been outlined as (1) the preservation of the patient's individuality, (2) the assumption that patients are trustworthy, (3) the notion that good behavior must be encouraged, (4) the premise that patients must be presumed to retain the capacity for a considerable degree of responsibility and initiative,

and (5) the provision of activity and a proper working day for all patients.

Most day programs would subscribe to these notions, and in this sense they may be called therapeutic communities of the general type. The program under discussion here, however, is a therapeutic community proper. In such an organization a number of characteristics are added to the general ones defined above. The therapeutic community proper is always small enough so that all members know each other well. Regularly all of the people in the community, without exception, meet together to consider problems. There is a strong interpersonal slant to the general approach; the prevailing ideology tends to be that an individual's difficulties are mostly in relation to other people and that these relationships can be examined in discussions, understood, and remedied. Much of the activity which occurs within the community might be termed the social analysis of events. Anything which occurs in the unit may be discussed in a meeting and an attempt may be made to understand what happened. Implied in this is a far greater concern with immediate events, with considerably less attention being given to the genetic basis of behavior. Indeed, attempts to introduce genetic explanations (which relate current behavior to what has happened in the past) are likely to be seen as attempts to evade responsibility (a popular song, for example, concluded that the results of psychotherapy were to convince the patient that "everything I do that's wrong is someone else's fault"). Attention is given to the freeing of communications upward and downward and to flattening of the authority pyramid, and there is an approach toward equality of all indi-

viduals within the structure. All persons are asked constantly to examine their roles, but this is perhaps applied more strenuously to the staff, among whom there is a considerable blurring of roles as they are traditionally defined. The characteristic themes of the therapeutic community proper are said to be permissiveness, democratization, communalization, and reality confrontation.¹²

Lest all declare with agility that these goals, too, are their own, let us pause to recognize the full implication of what has been said. The thoroughgoing application of these principles will result in practices generally inimical to those trained in the usual professional disciplines. To give but one example, the ancient and quasi-sacred right of privileged communication must be completely overturned, at least in the sense it is usually employed. No communication between any two people within the setting, written or verbal, can be considered privileged; every communication may be brought up at any time and in any setting within the structure of the community. There are, in essence, no secrets, nor can there be if each person within the community is to be a therapeutic agent toward all others. To be effective therapeutically has long been based on a thorough knowledge of the other. This is the reason for the history-taking which has always been a part of therapeutic endeavors. If all are to share in the endeavor, all must possess the requisite information. Thus all evaluations of individuals are public, not private. It is a logical extension of current practice, though a painful and difficult one at first. It is especially difficult when these considerations are made to apply with equal vigor to the staff of the program as well as to patients.

Another painful issue is that of democratization. Its introduction poses a dilemma: "To give treatment, it is believed that the use of power must be avoided; to run a hospital it must be used in some degree."⁴⁷ For example, although the physician-director of such a unit may delegate much of his responsibility for its therapeutic efforts, he cannot so delegate his legal responsibility. The degree to which a democratic ideal may actually be achieved in a therapeutic community is variable. Among other factors it depends upon the degree to which the staff professionals are able and willing to relinquish the authoritarian perquisites which have accrued to their professional roles. This, in turn, depends very largely on the degree to which the individual staff member derives his or her personal identity, his or her *raison d'être*, from their professional identity. The more a person perceives himself as whole apart from his professional role, the more likely it is that he will be able to relinquish aspects of that role when necessary.

To many, the democratic ideal implies equal influence of each upon each, that no man shall rise above his fellows. In practice, hierarchies form within all human groups. Our feeling is that hierarchical structure is neither good nor bad in and of itself. It depends upon the basis of the structure. If its basis is professional rank, that is one thing; if it is what could be termed right action, that is another. That is, if the doctor is right, it is not because he is the doctor, but because he is right. His being a doctor may in some way enable him to be right, but then, being a patient may enable another person to be right. In most traditional, authoritarian medical

settings, the doctor is right because he is the doctor. It is that which we seek to avoid.*

When these principles are carried to their logical conclusion it becomes apparent that one condition must obtain if a hierarchical structure is not to be antidemocratic. The condition is that all positions in the hierarchy must be accessible to everyone in the community, providing only that the individual fulfill the conditions set by the community for occupancy of those positions. In general there must be no *prima facie* exclusions on grounds of status, race, religion, education, or other factors. In terms of what has been said above, an individual capable of consistent right action toward other individuals (making the assumption, of course, that this kind of action is highly therapeutic) ought to be able to rise readily in the hierarchical structure of the program. In other words, any member of the program who demonstrates consistently an ability to be therapeutic with other members ought to be able to assume a position of therapeutic responsibility, i.e. that member ought to be able to become a part of the staff.

Once again, therefore, it is apparent that most treatment programs do not truly fulfill the logical implications of the therapeutic community concept. In most instances, insuperable barriers are placed in the way of the patient who would become a staff person. Many hospitals, for example, have an explicit policy of systematically excluding from employment of any kind an individual with a history of treatment for mental or

emotional disturbance. With respect to treatment situations dealing with lower-class persons, the situation is even more difficult. Regulations of various kinds set minimal educational standards as prerequisites for staff appointments, and commonly even these minimal requirements are far beyond those which a lower-class person, however well-motivated, could reasonably expect to achieve.

Fortunately, the program under discussion is part of a community mental health center which is deeply committed to the general philosophy outlined above.³² The usual barriers do not exist. As a result, three of the seven members of the staff of Our Place are people who originally entered the program as patients. They occupy positions of major responsibility, such as the leadership of therapeutic groups, the conduct of home visits, the supervision of special projects, and other activities identical with the responsibilities of other members of the staff who are professionals. In addition they are an important part of all general policy decisions made by the program.

That they discharge these responsibilities effectively and competently should come as no surprise. In many ways, the program is more meaningful to them than to the professional. The professional, in a sense, is *in* the program, but not *of* it. For the former patient the program has generally occupied a critical position in his life history, and his devotion to it is likely to be of a different variety than that of the professional, who is also devoted but in

* Semantically our policy corresponds to the distinction between "authoritarian" behavior, which we disavow, and "authoritative" behavior, which we espouse. H. W. Fowler¹⁸ states: "The differentiation is complete: *-arian* means favorable to the principle of authority as opposed to that of individual freedom; *-ative* means possessing due or acknowledged authority; entitled to obedience or acceptance (OED)."

another fashion. Perhaps more important than the meaning of their staff positions to former patients is the meaning of the fact that former patients *are* in staff positions to other members of the program. Most of all it means that the often-stated position that each member must and can help every other member is more than "just talk." Obviously if the staff values the therapeutic capabilities of members so highly that they have asked some to join them, they truly believe that these capabilities exist. It also means that they can if they wish become a truly vital part of the program. This is in contrast to other programs, even those in which a patient government exists; the only status within the program to which the patient can aspire is that of patient. Since he entered with that status and will leave with it, his motivation to rise within the hierarchy is correspondingly less. Our experience has been that one of the most potent motivations for changing behavior in our program is the aspiration to rise within the hierarchy. It is potent because it is demonstrably possible. Each day, the member is faced with those who have done it.

There are many other aspects of the therapeutic community concept which, if faithfully pursued, would also lead to practices as far from current norms as the overturning of the confidentiality principle and the use of ex-patients in staff positions of responsibility. To fully explore them here would be to over-emphasize this aspect of the day program. Moreover, the therapeutic efficacy of such a program, though apparent to many on an anecdotal level, can scarcely be said to have been conclusively proven.

It is hoped that this discussion will lend credence to the value of the distinction between the "general therapeutic community" and the "therapeutic community proper," so that the term does not become as meaningless and as non-specific as many psychiatric terms have become. If people pay lip-service to the concept of the therapeutic community without realizing its implications, the potential of the concept for generating growth within the profession will be destroyed.

THE IDEA OF MULTIPLE INTERLOCKING GROUP THERAPY *

To some extent, groups of a therapeutic nature are implied in the ideas of the day hospital and of the therapeutic community as discussed above. In fact, it has been said that "before a true psychotherapeutic community in particular ever develops, the participating therapists must almost proscribe individual treatment."¹⁸ In our setting this line of reasoning has been taken to its logical conclusion. Formal 1:1 interaction between staff and members is strictly prohibited. Informal interaction on a 1:1 basis does occur, and it would be unreasonable and even grotesque to prevent it. But all of the most significant interactions in the treatment program occur in various group settings.

Our reasons for this prohibition are multiple. First, as implied in the discussion of confidentiality, formal 1:1 interaction tends to be contrary to the notion of a therapeutic community proper. The participants constitutes a secret society whose aims may be quite different from those of the general society of the community. Even if the content of the formal interaction is

* I am indebted to Mr. John Dunham, M.S.W., for this conceptualization.

shared it is rarely fully shared, and the affect cannot be shared secondhand. The wholly confidential interaction tends to be a divisive element in an open society. Thus:

*Don't let him know she likes them best,
for this must ever be
A secret, kept from all the rest,
Between yourself and me.*⁹

Next, we consider group therapy in general to be a wholly adequate form of care-giving which does not require a backstop of individual therapy in order to be effective. We also feel that group treatment methods are not only more generally applicable to a wider variety of personal difficulties, but that they are in general more effective. They permit a more active testing of reality and of interpersonal effectiveness than is possible in individual therapy, providing much more consensual validation; and these areas are primary targets in the therapeutic community. Moreover, experience indicates that group therapy is much more effective in situations in which a considerable disparity exists between the professional and the patient, whether it be in terms of race, educational background, socioeconomic status, or other factors.³ Communication barriers are readily overcome, more accurate and comparative evaluation of life situations is possible, and professional-patient differences can no longer be used effectively as resistances. Since such differences will obtain in most community mental health centers, a strong emphasis upon groups is indicated. In addition, group experience is an unequalled method of training individuals to be effective therapeutically toward others and has been the backbone of most

programs which have succeeded in this goal.^{8, 32}

Although group treatment methods permit us to deal more effectively with a larger number of patients utilizing a small staff, we feel this is one of the least critical justifications of their use. We fully concur with Major Foulkes, who remarked testily, "A note of warning may be permitted here: not to connect 'group therapy' as such with a notion of mass production. It is not a sausage machine!"¹⁵

Finally, in our emphasis upon groups there is also in some measure an element of expediency. The focus of traditional professional training has been for so long upon individual interaction that the professional feels much less comfortable in groups than in 1:1 interaction.⁴⁰ There is the risk that this may result in a covert avoidance of the group process, in which the significant therapeutic transactions are made individually, while the groups become an empty charade. The general injunction against formal individual therapy in our setting prevents this from taking place.

At this time a minimum of 22 different kinds of groups occur within the day program setting. Groups may be based upon age, sex, diagnosis, length of time in the program, position in the house hierarchy, verbal productivity in other groups, vocational training status, or other attributes of the individual. On the other hand there are groups related more to specific group techniques, such as psychodrama, analytic group, family treatment groups, confrontation groups,²⁶ and from time to time marathon groups.³⁸ It is important to emphasize that the schedule is constantly in a state of flux as the need for some types of groups becomes apparent and

the need for others abates. To this group situation the phrase "multiple interlocking group therapy" has been applied.

We believe that the term is more than descriptive. Multiple interlocking group therapy seems to differ significantly from standard group therapy in a number of important ways. One dimension of difference, of course, is intensity. A given member of the day program participates in from three to five groups each day, as opposed to the usual one group per week in standard group therapy. This might only be a matter of duration rather than intensity, but it is our impression that there is a cumulative effect. A person constantly exposed to group sessions becomes progressively more open to the group process, whereas intermittent exposure permits the maintenance and the shoring-up of characteristic defensive strategies. By the time the next weekly session comes around, the individual has once more sealed over and is closed rather than open. Life experiences rather than being fresh in their impact have been sorted out and categorized according to the old, maladaptive patterns. Or, they may simply not be reported. Such occurrences are far less likely in a setting of constant, repetitive group experience.

Moreover, the experience occurs within a setting, the milieu of the program. This has several important implications. Since elements of the setting are warm and supportive, it is much more feasible to be direct and confronting in the group. The work of a given group session, for example, might be to systematically pick apart the image which a member characteristically feels he must project in order to be accepted, and to expose the fear and guilt which lies beneath. Were it not for the fact

that the ambience of the house (or perhaps the support of a subsequent group on the same day) existed to balance the therapeutic approach, a direct approach of this kind would be more hazardous. The individual would be left bereft of his old defenses and with nowhere to go. But against the backdrop of a warm, concerned and giving milieu such an approach is both possible and effective. In once-a-week group therapy, it is our feeling, such a confrontation would have to be considerably toned down, if used at all. Thus, paradoxically, though the program utilizes nothing but group therapy, it is not a setting in which group therapy as such can be effectively taught. What occurs is different from standard group therapy and is rather multiple group interaction within a milieu.

The fact that some of the groups are devoted to rather circumscribed sectors of the functioning of an individual provides an additional dimension for the program. A given individual has many social roles. In standard group therapy, only a few of these roles may undergo therapeutic scrutiny, either because time is limited or because the individual may successfully manipulate the group to preclude discussion of a sensitive area. By overtly focusing the group process onto a delimited area (such as work plans and history, for example) the possibility of avoiding the area is eliminated. Conversely, it would be difficult to so focus without the existence of other groups which met other needs. Thus the groups tend to complement each other and together form a more coherent whole.

Providing multiple kinds of settings within the program enhances its flexibility in another way. Although there tends to be some constancy in the responses of a given individual to various

groups, it is also true that the individual does exhibit a differential degree of response to different kinds of groups.^{41, 42} Thus, multiple settings mean a program in which more individuals will find something for themselves. It also provides the opportunity for learning systematically, and hopefully predictively, which individuals do best in which of the settings. When the time comes that this can be specified more accurately, it is expected that the effectiveness of the program will be greatly enhanced.

One of the major tasks of both staff and members engaged in such a program is to assure that the multiple groups do in fact interlock, and that they are not simply a string of isolated experiences. Here the absence of the confidentiality rule becomes very important. Obviously if it were not permitted to carry important information from one group to another there would be little interlocking. The requirement of a therapeutic community that all persons within it meet together regularly also acts to assure interlocking. Many difficulties which arise in groups are referred to the daily community meeting, and vice versa. Since a major task of the staff is to expedite communications, the structure of the program must provide constant opportunity for the staff to interact as a group. One experience has indicated that it is important this be done at least twice daily in a formal sense, not to mention innumerable informal colloquys. Finally, if the group process is valid for other groups, it must also have validity for the staff as a group. We have found it important that the staff meet regularly, not only to exchange communications and make policy, but also specifically for the task of resolving the interpersonal differences between

staff members which inevitably arise, and which would otherwise be quite disruptive of the general program.

THE IDEA OF A NONMEDICAL THERAPEUTIC SETTING

The excessive professional pride of physicians was well known to Moliere and to Hogarth. Time has not lessened its intensity. Perceiving himself as the rightful inheritor of the healing touch of the kings, the physician has tended to usurp the therapeutic prerogative. This is often unrealistic even with respect to physical illness, and is doubly so in the matter of social and psychological problems. The training of the psychiatrist, for example, is probably not as specifically useful as is the training of other mental health professionals.⁸⁵ Sensitive non-physicians have long been aware of the unhealthy side-effects which physician-created institutions have had upon persons within them. In commenting upon the personal experience with a tuberculosis sanitarium which formed the nidus of *The Magic Mountain*, Thomas Mann observed:

You will have got from my book an idea of the narrowness of this charmed circle of isolation and individualism. It is a sort of substitute existence, and it can, in a relatively short time, wholly wean a young person from actual and active life. Everything there, including the conception of time, is thought of on a luxurious scale. The cure is always a matter of several months, often of several years. But after the first six months the young person has not a single idea left save flirtation and the thermometer under his tongue. After the second six months in many cases he has even lost the capacity for any other ideas. He will become completely incapable of life in the flatland.⁸⁴

The applicability of these remarks to psychiatric treatment institutions is obvious and the same factors have been commented upon in much the same

fashion in the psychiatric literature.⁵² Many other authors have expressed dissatisfaction with psychiatric treatment facilities even in this enlightened age.^{10, 11, 21, 38, 51, 58}

What is less regularly commented upon is that the essential failure of these institutions may reflect a fundamental problem in the education of the physician. The same tendency to relate to the patient in an authoritarian, distant, and unempathic manner and to usurp his autonomous functions which is seen in the institutions is tragically often exactly paralleled in the manner in which the individual doctor relates to his patients. Many have noted that these are not the characteristics of entering medical students. They seem to be acquired as a result of professional training.^{6, 14, 22, 24, 32}

The abuse of certain prevalent models in medical education may have a good deal of relevance to this problem. Two such models are the model of the surgical emergency and the model of the psychoanalytic situation. In both exists the requirement, albeit for different reasons, that the physician hold himself aloof from the patient as a person. The reasons may be valid. The error lies in the generalization of this type of relationship from the very special, particular, and limited situations in which it is correctly used to all of medical practice. It is no more appropriate to approach every medical situation as if it were a surgical emergency than it is to approach every psychological contact as if it were a psychoanalytic hour. This is true in every respect, but none is more important than in terms of the doctor's (or other professional's) relationship to the patient. There is evidence to suggest that, from a psychotherapeutic

viewpoint, the lack of such qualities as empathy, warmth, and genuineness in the therapeutic situation may be harmful to the patient.⁵⁴ All too often, the overzealous application of the surgical and psychoanalytic models results in exactly these deficiencies.

On the other hand it would be expected that the nonmedically trained nonprofessional who has not been subjected to these models over a long period of time would be spared their vitiating effects, and would retain his natural spontaneity, warmth, empathy, and genuineness. Studies and projects carried out in this area indicate that this is indeed the case.^{8, 32, 54} Moreover, in recent years it has been obvious that nonmedical therapeutic settings operated largely or exclusively by nonprofessionals have been highly efficacious in areas in which professional success has not been conspicuous. Such programs as Alcoholics Anonymous, Synanon, Daytop Village, Gaudenzia House, Gamblers Anonymous, Recovery Incorporated, and even Weight-Watchers owe relatively little to medicine or medical ideas and have profited enormously by the insights which the nonmedical person can bring concerning the human condition. Perhaps this was why Freud was so adamant that the practice of psychoanalysis not be limited to physicians.¹⁷

It would appear, therefore, that the time has come for an agonizing reappraisal of the medical format which most treatment programs take. There has been a good deal of discussion about the lack of adequacy of the so-called "medical model" of treatment. In the day program, an attempt has been made to fashion a program which is not along the lines of the medical model. This at-

tempt extends to the smallest details. For example, medical words have been expunged from the local vocabulary (e.g. "member" instead of patient). Professionals are not allowed to display their certificates, and are on a mandatory first-name basis with all other staff and members. No medications are dispensed within the confines of the program. The very name of the program, *Our Place*, was settled upon somewhat uneasily because it did not prove possible to find another name devoid of all suggestion of a medical treatment facility.

But very clearly the largest single factor in the attempt at conversion to a nonmedical model has to do with the use of nonprofessional personnel. As continuing experience demonstrates repeatedly the capabilities of such personnel, the direction in which the program is moving has become clear. The day-to-day operation of the program is now almost exclusively in the hands of its nonprofessional workers. They are almost entirely responsible for its routine workings, and in time will assume total responsibility for this phase of the program.

While it is the case that only by this means can a nonmedical treatment program be approached, the move is not being undertaken to assure the purity of the theoretical model. Rather, it appears to offer the most practical resolution of the problem of the relationship of the professional and the nonprofessional. Though there are some drawbacks to professional training, the professional does possess specialized technical knowledge which the nonprofessional lacks. For example, the physician is competent to deal with medical problems and to prescribe medications. However, there are only a small number of professionals

available. It is therefore important that the maximum efficient use be made of their very particular competencies, and that they not be required to provide other kinds of services which, for example, the nonprofessional person can provide as well or better. With the nonprofessional dealing with the nitty-gritty clinical details of day-to-day operations, the professional is free to employ his specific and exclusive talents in areas where they are most needed. The operation becomes, therefore, a viable partnership in which each does what he can best do.

It may be argued that the technical knowledge of the professional is needed in the day-to-day management of individuals. This has been the general contention of psychiatry. It is based upon knowledge of affective and cognitive data derived largely from the psychoanalytic experience. Theoretically it holds in general that the alteration of the thought and feelings of an individual is a necessary prerequisite to behavioral change and, as a corollary, only an individual knowledgeable about the complexities of such thoughts and feelings will be capable of bringing about such a change. Recently, however, a body of knowledge has been elaborated from such diverse sources as learning theory, existential philosophy and the clinical experience of the nonprofessional treatment organizations mentioned above which suggests exactly the opposite, namely, that changing a person's behavior is a necessary prerequisite to any change in his affect and cognition. Though there is little definitive empirical data on either side of the argument, the behavioral approach does seem to warrant exploration if only because psychiatrists as a group have not been in

general effective in producing marked behavioral change. Experience has indicated that the nonprofessional, unencumbered by an elaborate theoretical superstructure and a nondirective technique, is very effective in dealing directly with the individual's behavior. Therefore the nonprofessional is well equipped to manage the day-to-day operation of the day program, which consists largely in dealing with behavior in the setting described above.

To run counter to the generally prevailing attitude and practices toward treatment is never a comfortable position to be in, however much one may believe in what one is doing. The final goal of the program is to unlock human potential and promote person-to-person engagement. One of the reasons this may not have been more widely attempted in the past is that it is personally far less comfortable. One puts oneself on the line as a person, rather than using one's profession as a shield. In time to come, departures from this goal may well be taken surreptitiously for this reason, and we will have to be vigilant lest we be overcome by our own rationalizations.

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REVIEWS OF THE LITERATURE

AMERICAN MEDICINE: MEDICAL CARE AND EDUCATION

Julius B. Richmond

Cambridge, Mass.: Harvard University Press. 1969.

Julius Richmond, distinguished researcher in early infant behavior and equally distinguished professor of pediatrics, medical educator, and dean of the College of Medicine at Syracuse, director of Head Start, AOA member and former vice president, has in a brief volume traced the historical growth of American medicine, medical care of the American people, and the development of medical education.

The Flexner report in 1910 was an outgrowth of the AMA Council of Medical Education's progressive concern with the haphazard medical school programs which had no overall program of systematic teaching of knowledge to its students. The impact of the report was the adoption of a four-year medical school curriculum, the introduction of laboratory courses, and the improved quality of teaching through employment of full-time faculty and introduction of the clinical clerkship. It also put medical schools into a university framework and for the first time incorporated research into the teaching program. The AMA began to accredit teaching programs. Their effort however also reduced the number of schools and of graduating physicians to serve the population.

Throughout the volume there are recurring themes related to the needs of the population to be served versus the needs of organized medicine as represented by the AMA to professionalize medicine, keep it elite, and make its members, although overworked, affluent and important members of society.

Of concern to all mental health professionals is the documentation of how this professional organization evolved to become politically powerful, the guardian of an elitist group, and ignored its early charge and concern with the best and most effective medical care for the people it serves. Of interest is how the hierarchy of the association repeatedly ignored its own committee recommendations on health insurance and methods of educating more physicians for a burgeoning population. Despite the increased amount of knowledge and its inevitable specialization, the AMA fought group practice although it had long been clear that no single physician could encompass all the knowledge necessary to serve his patients adequately.

The whole question of prevention of disease made possible by new discoveries did not concern the hierarchy of the AMA nor did the medical care of those patients who could not afford medical care. Thus, the use of public funds to develop methods of care and research and preventative medicine not possible under private aegis was unequivocally opposed by the AMA though very much supported by some of its committees and members.

Following World War II, with increased research and specialization and new support by the government to medical schools, the question of delivery of service still did not concern either the AMA or the emerging organization of medical schools.

At the same time, another phenomenon occurred of historic and current interest to the mental health professionals. Teaching in medical schools declined as research was rewarded by both status and monetary rewards and mushroomed beyond all expectations.

The salient issues of how these activities relate themselves to the increasingly critical issues of meeting our national needs is a prevailing theme of Richmond's brief volume. It is clear that no one wanted to tackle this problem of finding methods of meeting the health requirements of our nation, and there was characteristic unresponsiveness of medicine to the public issues of need for increased medical manpower of various kinds.

Third-party payments, so current today via health insurance and medicare, helped organized medicine avoid for some time the most critical issue of outpatient care; paid-for hospitalization where the greatest investments of medical schools and some physicians were involved was put first. The question of using our increasing knowledge in a new framework for prevention remains a poor second cousin to be looked after by undermanned and underpaid state and local health departments, which themselves are often hampered by a disease-model of prevention rather than a more global social, public health model. Prepaid universal medical services which must be prevention oriented to survive were and are still opposed by organized medicine. Only currently is the AMA considering the development of comprehensive health services.

Also of major concern to us is that specialization and fragmentation of medicine has dehumanized it and resulted in a major patient complaint and concern. Exacerbation of illness and increased psychological illness also would seem to be due to dehumanization, especially in the hospital setting.

It is only recently that poverty as a real issue in our affluent society has even been looked at, and still it is not most squarely faced. Its implications for new and better methods of medical care only begin to be indicated by the rise in infant mortality in this nation and the increased use of county and city hospital emergency rooms as substitutes for ongoing medical care.

Despite the rise in mental illness and its cost to society, only fragmented programs with no prevention aspects and no services for children and families have been legislated in the 1960s. Even heart, cancer, and stroke programs have been developed in

terms of minimal research and patient care—not epidemiologic causation and prevention.

Patient care across the board, prevention via elimination of malnutrition, and early and regular examination of our population, although less costly than hospitalization and the overall effects of poverty, are still to be legislated. The development of a variety of medical care personnel to service our population also remains a nebulous goal despite innovative efforts by some agencies and communities.

The involvement of community representatives in the kind of services they receive is still very much objected to by many members of organized medicine. Thus, the responsiveness of medicine to its patients' human requirements and to the needs of the nation, be it on the level of organized medicine or medical schools, is still that of the reluctant dragon.

New models of medical practice that could be more responsive to community needs and could ensure comprehensive care still await implementation. Richmond strongly indicates that only the implementation of these models makes possible the needed training and development of personnel required for continued comprehensive care and its basic theme of prevention.

Only then can we begin to talk in terms of health rather than disease, of keeping people well rather than treating their illnesses. Only then can the already present techniques be automated for use in screening and prevention and for the training of new medical personnel to do parts of the job and the retraining of the physician. Physicians will not be attracted to such medical practice until trained and until practice of comprehensive preventative care is recognized as prestigious, critical, and important by their teachers.

Richmond also points out that until poverty is recognized and dealt with and its implications for health care understood, we will continue the expensive hospital-based care rather than the less expensive outpatient care with periodic preventative examinations which can be used to benefit all of our society.

He finally emphasizes that accident prevention, the first cause of death in chil-

dren, and environmental pollution, our most critical general health hazard, depend strongly on educational programs which involve a partnership between medicine and the community. He also emphasizes that mental illness, our greatest health problem, is inextricably interwoven with the quality of life in our society. This also implies a new partnership between professionals and the community.

The need for a rapid response to the urgent challenges of health, mental health, and education of our whole society is made apparent in this volume. Julius Richmond has made it eloquently clear that we, as mental health professionals who can recognize both the needs and danger signals, must be in the forefront of involving our fellow citizens in action now to eradicate poverty and to provide the varieties of care and prevention which our society can afford if it will.

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SOCIAL CLASS, RACE, AND PSYCHOLOGICAL DEVELOPMENT

Martin Deutsch, Irwin Katz, and Arthur R. Jensen, Eds.

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Several contributions in this book make particularly valuable additions to our understanding of the interrelationship of social class and/or race in the growth of children. The book is divided into four sections. The first section consists of an excellent discussion of the biogenetics of race and class by Gottesman. The other three sections cover topics which relate environmental factors to perception and intellectual development, social-psychological issues, and implementation of strategies relevant to educational interventions. The book was sponsored by the Society for the Psychological Study of Social Issues, and unfortunately its publication was delayed for some years.

As with most collections of edited papers the contributions are uneven. In many in-

stances, the chapters were written some years ago and do not include recent research, resulting in an overly general and insubstantial presentation (e.g. the chapter on perception). Whiteman and Deutsch's chapter also presents little new data. Their major contribution is to establish the validity of the Deprivation Index, which seeks to integrate the effects of social class related variables that correlate with IQ and reading achievement scores. Probably due to the lag in publication time, other such scales—R. Wolfe's scale of environment process variables that relate to scholastic achievement, to cite but one instance—were not mentioned. The Wolfe scale, by focusing on a broad range of dimensions that describe within and cross social class behaviors, represents a richer and more complex schema for characterizing the contribution of environmental variables to school achievement than the Deprivation Index.

J. McVickers Hunt concisely and lucidly summarizes the arguments he set forth in his book (1962) regarding the dynamic nature of intelligence and the salient contributions of experience to its phenotypic expression. A number of chapters survey the case for educational interventions in infancy and early childhood (Stendler-Lavatelli) and early school ages (Bereiter, Gordon). Rosenthal and Jacobson compellingly present the rationale, supporting evidence, and their own data demonstrating the role of teachers' expectations as determinants of self-fulfilling prophecies in the classroom. While the "Rosenthal effect" is now widely known, the supporting evidence and the details of this study have not been as readily available as Hunt's epochal book. These chapters, then, cover well-trodden ground that has been more completely presented elsewhere.

The book does contain several very significant contributions. Gottesman's discussion of the biogenetics of race and class is very illuminating, especially in light of the current reconsideration of the contribution of genetics to intelligence. Gottesman discusses the genetic evidence relating to race and social class separately. Tackling the problem of race differences in intellectual performance, he points out again the

limitations of a construct of intelligence based primarily, or solely, on Binet types of scores. He illustrates this statement by citing Kennedy's (1963) study of 1,800 southeastern Negro children which reported a mean IQ of 80.7 on the 1960 revision of the Stanford Binet. 18.4% had Binet IQs less than 70. Gottesman comments, "That such discrepancies primarily represent a form of overall stimulus deprivation, somewhat like the sensorily handicapped rather than 'genetic inferiority,' is strongly suggested by the manner in which the mean IQs drop solely as a function of age (read exposure to an inadequate environment). While the mean IQ of the 6-year-old group was 84, that of the 13-year-olds has dropped to 65; the proportion of IQs below 70 in these two extremes of the Kennedy sample was 8.8% and 66.7% respectively" (p. 27).

He proposes that the contribution of heredity to a trait such as intelligence is to think of heredity as determining a norm of reaction. As the genotype of the individual indicates potential levels of functioning at or above the average phenotypic IQ, the innate intellectual functioning is more susceptible to upward or downward changes depending on the child's experiences. It is only when two individuals or two groups come from equally favorable environments that the difference in measured IQ can be interpreted to indicate a difference in genetic potential. He summarizes his discussion by concluding that at the present time "Negro and white differences in general intelligence in the United States appear to be primarily associated with differences in environmental advantages. (By contrast) social-class differences in general intelligence is stratified, open-class societies appear to be moving in a direction where such differences will have an appreciable genetic component" (p. 46).

Jensen has done a remarkable job of synthesizing the data relating to language development from the context of an associationist learning position, and defines the stages in the development of verbal control of behavior. He also sets forth the experimental paradigms by which one can test for the potentiating power of the

verbal mediator in problem-solving. This is a fine contribution that should help focus research on the oft-observed verbal deficit of low-status children.

The most compelling chapters are by Proshansky and Newton on nature and meaning of Negro self-identity, and Katz on factors related to Negro performance in the desegregated school. What oppresses the reader of these contributions is the degree to which the black child and adolescent get the message of a de facto white racism, i.e. a judgment that he is "different," or inferior, when compared to the white child, and the lasting negative impact on the child's sense of his competence.

Proshansky and Newton describe the development of self-identity in the Negro. For analytical purposes the writers distinguish between the child's ability to make conceptual and evaluative distinctions regarding his racial group membership. The conceptual ability to make racial distinctions increases in accuracy from 3 to 7 years, with the greatest increase occurring during the fourth year. Consistent conceptual understanding doesn't develop until 8 to 9 years, as the child achieves increasing levels of generalization. In parallel with this process, the evidence is presented for the early acquisition of negative emotional and evaluative attitudes and feelings about being black, using a variety of different techniques, such as playmate selection, drawings, doll play, and picture tests. When the Negro child is asked to evaluate being black as opposed to being white, he has more often chosen white rather than Negro dolls or playmates, attributed more negative descriptions or feelings to Negro stimuli, and drawn Negroes much smaller in size relative to whites, often with missing or mutilated body parts. The Negro child is not merely expressing a preference to be white but, more significantly, suggests a rejection or hostility toward his own racial group. While the social reality dictates a decrease in the tendency of the Negro child to identify with the white group and reject his own group as he grows older, the older youth certainly must continue to be "sensitive" to the question of "who am I," and to characterize himself in unfavorable terms, i.e. to reveal a nega-

tive self-image. There has been little direct study of this process into later childhood and adolescence. However, as the authors indicate, the indirect effects of the negative self-image are reflected in the abundant reports of symptoms of personality maladjustment in older Negro youth and in some real inconsistency between the educational and occupational aspirations of these youth, and/or their parents. In a nutshell, while they tend to aspire high educationally and occupationally, they tend to expect to attain much lower level occupations in adulthood.

Methodologically, the authors point out that most studies have compared lower-class Negroes to middle-class whites but tend to generalize conclusions from these studies to all Negroes regardless of social class or geographic locations. But, as they point out, Negroes who have achieved economic and occupational success probably have different identity problems than the lower-class Negro. The white middle class is used as the yardstick for most standard measures, be they intelligence, achievement, personality, family structure, occupational choices, amenability for psychotherapeutic treatment, etc. The authors quote Georgene Seward's (1956) indictment of this practice. "In the case of the Negro, to follow white norms may mean indicting an entire subculture for deviations forced upon it by exclusion from the main currents of the dominant culture" (p. 181).

In the context of the negative self-concept the black child develops, Katz's discussion of the factors influencing response to desegregation also includes a cogent analysis of the elements of the desegregated situation which may induce stress and conflict for the Negro child. In an encouraging vein, Katz summarizes the evidence regarding the effects of desegregation and concludes that there are few findings that indicate widespread academic failure among the Negro students. Based on scanty evidence, it would seem that the earlier the Negro child is integrated, the better his school achievements. (Note, however, the frequent pattern of desegregation plans which integrate one grade per year starting with the senior year of high

school and move downward in age.) As the proportion of white pupils in schools increased, Negroes' scores on achievement tests tended to rise, with no demonstrable decline in the performance of white students. Rather the black students tend to respond favorably to the higher educational quality found, on the average, among the white students. Successfully achieving students in integrated (more than 50% white) rather than desegregated schools reported greater cross-racial acceptance than poorly achieving Negro students.

The scanty evidence available indicating the positive effects of integrated schools is encouraging though the resistance of the white society to more than token integration and the separatist thrust of the black nationalist movement suggest it might be an academic issue, at least for the present. More appalling is the paucity of data available 15 years after the Supreme Court decision. Schools demonstrate an incredible reluctance to be evaluated on the basis of their performance, and citizen and professional groups have allowed them this luxury.

Of particular interest to mental health professionals is the theoretical formulation of the factors that affect the performance of the black student confronted with more intimate contact with whites. The Negro student who is integrated into a racially mixed school must consider the implicit social threat from white students and teachers, must take account of the threat of failure, especially if he perceives the standards of the new school as substantially higher, and must determine whether in these circumstances he can perceive the possibility of success. Katz repeats the theme of Proshansky and Newton's discussion. Negroes tend to feel they are intellectually inferior and to accept the white group's stereotype of Negroes. In a series of experiments he documents the reluctance of the Negro college student to credit his own competence over that of his white partners and his fear to compete with the white partner on intellectual tasks, even when the task was rigged in his favor. When he saw the possibility of succeeding on a task, he worked harder for a white than for a Negro tester. The

dictum of the Negro's inferiority strongly advanced by the white society does deeply affect the Negro student's sense of his own capability and his willingness to respond with constructive work to the challenge presented by good schools. If one needs further evidence to support the conclusion of the Kerner Commission, these two chapters document to a depressing degree the psychological effects of the white racist society which the Negro child experiences very keenly as he grows up.

Rosenthal and Jacobson's chapter on the effects of teacher expectations in influencing educational outcomes adds yet another depressing set of factors, since teachers are the white group that interacts most generally with the black urban slum child in the most uncomfortable context for this child—an achievement-oriented classroom. In the face of the widely held belief in the Negro child's intellectual inferiority, the teacher's low expectations of success must directly affect the poor educational outcomes.

In summary then, several chapters make this book very timely and instructive. The care-giving services must understand more clearly the phenomenological context of life of the poor child, and particularly, the additional complication of color. Poverty colors one's experiences and one's views of life very differently, and many of us who grew up in the thirties seem intent on forgetting it. The comfort and smugness of our theories and the projections of our strivings have helped us to forget very rapidly. The experience of being black must cause us to pause and ponder, since advertently or inadvertently we have helped create and perpetuate the distortions which the black child suffers. This book, though belated in its appearance, gives us additional data and conceptual frameworks that should facilitate and speed the process of reconsideration and reformulation that the helping professions are undergoing to cope more actively and more positively with these most critical problems.

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THE CRIME OF PUNISHMENT

Karl Menninger

New York: Viking Press. 1968. 305 pp. \$8.95

DELINQUENTS AND NONDELINQUENTS IN PERSPECTIVE

Sheldon and Eleanor Glueck

Cambridge, Mass.: Harvard University Press. 1968. 268 pp. \$8.50

As one might suspect from the provocative title of *The Crime of Punishment*, Menninger severely criticizes the state of affairs in the U.S.A. concerning the treatment of offenders. The author does not mince words in bringing to the attention of the reader the injustice being done to people in the process of justice.

Quite correctly he begins by telling about adverse conditions which exist for many suspects before trial starts—a most important aspect, which, in view of this reviewer, is unfortunately not sufficiently appreciated as a locus for crime breeding. It is indeed astounding to learn that the Manhattan Bail Project, of which the author tells us, has not become the practice all over the States. For here is one instance of which it can be said that detention in jail pending trial, without using a selective approach, does not serve in the long run any salutary purpose. The same applies to juvenile offenders who await trial or who undergo psychological or psychiatric examinations in a remand or detention home. These examinations can in many instances be accomplished ambulatorily, but for many it is a good pretext to make use of such examinations within closed walls without thinking twice of its usefulness. No doubt that much can be improved in this field, which would virtually amount to crime prevention.

The author pictures the encounter some suspects have with lawyers who are put at their disposal by the court—in the name of justice—or who retain a defending counsel on their own. In the former instance the author gives the following example: "There was no conceivable way of proving intent to steal. Nevertheless, the attorney appointed to defend the soldier

actually assisted the prosecuting attorney in obtaining a conviction of car theft with a sentence of one to ten years in prison." On the latter instance he writes: "Many prisoners have exhausted their funds to retain lawyers who exist by preying on miserable, ignorant persons caught by the law. The lawyer may induce them to plead guilty, promising to get them off by his influence or by a private 'deal' with the judge or the prosecutor."

Shocking instances experienced by those sent to prison after conviction are reported by Menninger. Much has been written about this the world over for many years, and in some countries a new and more human approach is being tried out. One gains the impression that this is not happening in the States. But, conspicuous by their absence are any practical suggestions by the author to change matters in this field. What steps should be taken, for instance, to enforce appropriate teaching methods for all those who at the various levels are concerned with crime prevention, treatment, punishment?

A great part of the book is concerned with different and opposing attitudes between lawyers and psychiatrists, and conflict situations arising out of them. What struck this reviewer was the rather non-scientific nature of argumentation, the many quotations from newspaper reports, and the sweeping statements such as this: "I suspect that all the crimes committed by the jailed criminals do not equal in total social damage that of the crimes committed against them." Indeed, the title of this book is of a philosophic nature, but the way in which it is written is not expedient for a discussion on the crime of punishment. The author points to the disadvantages of the present system, practically from every point of view, but he leaves the reader with a feeling of dismay, despair, and helplessness. If conditions are such as described in this book, one expects some constructive points of how matters could be changed.

What impressed this reviewer, however, is that here is someone who *cares* about the matter he is writing about. For a foreign observer and reviewer it is very difficult to take issue with those deficiencies

which the author elaborates on. But it can be said as a general statement that, by reading the grim account given in this book one wonders why all these enlightened men and women, professional and laymen, do not accept this state of affairs as a most urgent challenge to change the existing conditions. Or to put it in the author's words: "Why don't we care? And if we do care, some of us, why not more intelligently and effectively?"

Delinquents and Nondelinquents in Perspective is the extreme opposite, in its outlay, contents, and way of argumentation, from Menninger's book. It is the result of many years of relentless efforts by the famous Gluecks in their endeavour to find out, by methodological research, facts concerning causation and prediction of juvenile delinquency. Whatever reservations some research workers may have concerning the work which has been accomplished over many years by the Gluecks, by each of them individually and by creating together as a couple, it has had an impact of considerable importance in this field the world over. In the preface the authors say that "the present work encompasses, on a descriptive level and at a stage of tentative interpretation, the findings of a detailed follow-up inquiry into the conduct of the juvenile offenders and the matched non-offenders of unraveling as they grew into adolescence and early adulthood." In other words, this is a followup of those boys who were investigated in *Unraveling Juvenile Delinquency*, published in 1950. This reviewer does not know of any similar detailed investigation in which a followup study on 438 delinquents and 442 nondelinquents was carried out. The figures given indicate very clearly the disadvantageous conditions which develop for the delinquents as compared to the group of nondelinquents, although both groups grew up in similar and much the same urban slums. As the authors point out, and this is indeed of great importance, both groups are of white origin and they come from the same underprivileged areas with very much the same background.

It seems that everyone who in one way or another is concerned with juvenile de-

linquents is impressed by the misery and want which is the lot of many of them. Yet the detailed account of their life history and their counterparts as given in *Delinquents and Nondelinquents in Perspective* are very impressive. The great importance lies in the very fact that we are faced in this book with facts and not with impressions. Concerning the parental background, for instance, the following was found, among others: "While mental backwardness existed in one fourth of the delinquents' maternal families, it had been found in only one seventh of the nondelinquents' maternal families. More significantly, however, such severe emotional abnormalities as psychoses, psychopathies, psychoneuroses, epilepsies, sex inversions, marked emotional instability, and pronounced temperamental deviation existed in one or more members of at least a fourth of the families from which the delinquents' fathers sprang, compared to but one-sixth of the nondelinquents' paternal families."

It is a commonplace that the school as such is an important factor when considering the various aspects of juvenile delinquency. It is also recognised that the school can play a vital role in preventing delinquent behavior patterns. While discussing this basic issue, a great variety of aspects have to be taken into account, which cannot be done in this context. Suffice it therefore to mention only one figure, which is indicative of the problem. The authors found that "no fewer than 95.6% of the delinquents, in contrast to 17.2% of the nondelinquents, persistently (and often seriously) miscondacted themselves in school." A list is given of what misconduct contains.

Faced with the enormous amount of disadvantageous conditions which is the lot of juvenile delinquents, it is gratifying to know that the authors have nevertheless come to the conclusion that "the malign influences of the slum somehow do not produce delinquency among the great majority of those who live in such potentially evil communities."

This leads us to the question: What are the special and peculiar conditions which make the group of delinquents so vulner-

able that they act in the way they do? It appeared to this reviewer that the authors answer would be twofold, namely, the biological makeup of the individual offender and a repetition of family patterns. To counteract such tendencies, much more imaginative actions geared specifically towards the needs of these children are necessary.

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PROGRESS IN BEHAVIOUR THERAPY

Hugh Freeman, Ed.

Bristol, England: John Wright & Sons. Baltimore: William & Wilkins. 1968. 94 pp. \$7.25

This volume records the papers delivered at a symposium for psychiatrists and clinical psychologists held in 1967 at the Postgraduate Medical Institute of the University of Salford, England. A concise but informative Introduction by Hugh Freeman is followed by seven relatively short papers: Behaviour Therapy and Obsessionality (J. L. Worsley); Experience in the Treatment of Alcoholism (Tom Kraft); A review of Behaviour Therapy in the Treatment of Phobic Symptoms (J. Trevor Silverstone); A New Technique for Desensitization (Dennis Friedman); Indications for Behaviour Therapy (M. G. Gelder); The Treatment of Homosexuality by Aversion Therapy (M. P. Feldman); Some Clinical Applications of Aversion Therapy (J. C. Barker and Mabel E. Miller). The volume concludes with a short discussion of the preceding papers by C. P. Seager.

To the extent that they focus upon matters practical rather than theoretical and avoid those distasteful polemics which characterize so much of the earlier writings in behavior therapy, the various contributors share a common platform. Nevertheless, as with most published proceedings, the volume suffers from some unevenness and lack of integration. While the 90 or so pages cover a fair range of topics, complete with illuminating case histories, no topic is presented in sufficient

detail to serve unsupplemented as a working manual for the uninitiated. For little more than the \$7.25 which the U.S. agents for the British publishers have the temerity to ask, the interested clinician can purchase any one of a number of more comprehensive texts in the field. (Incidentally, should a colleague in Britain generously decide to send his American cousin this very same edition as a gift it will cost him only 32s 6d, or \$3.90!). Nevertheless, the volume makes an interesting little overview to which the clinician will find it useful to refer, in conjunction with the many other sources that are readily available in both book and journal forms.

Apart from their intrinsic value, the various papers are of significance to this reviewer primarily to the extent that they represent a transitional stage in the development of behavior therapy from a laboratory exercise into a viable clinical science. As the editor points out in his Introduction, at one time behavior therapy consisted primarily of the more or less mechanical application of impersonal procedures derived from laboratory based S—R learning theory to the presenting complaint and little else. Gradually, as this volume exemplifies, behavior therapists began to recognize the limitations, as well as the strengths, of the early pioneers, with their oversimplistic emphasis upon conditioning as a synonym for all forms of learning. It is no longer assumed that all that is necessary in order to revolutionize the treatment of psychiatric disorders is the direct application of the traditional laboratory paradigms of classical and operant conditioning by the experimental psychologist.

Whereas the early texts on behavior therapy tended to propagate this assumption, later volumes—such as this one under review—reflect a healthy evolution and the impact of what Arnold Lazarus terms "the concept of functional behavior therapy." Relatively few behavior therapy techniques bear a close resemblance to either the classical or operant conditioning paradigms of the laboratory, and it is a tactical error to assume that daily life does, or should, conform to such models. Such simplification, necessary in the early

stages of behavior therapy, is now being gradually discarded in favor of a more sophisticated approach, one which recognizes the probability that additional, and possibly more complex, biological processes than "reciprocal inhibition" and "operant conditioning" permeate a therapist's relationships with his patient.

However, if comprehensive therapy represents the behavioral wave of the future, riding the crest of this wave is not without its dangers and one can very easily overshoot the mark and become engulfed in a sea of eclecticism and conceptual confusion. While for the most part the contributors to the present volume manage to avoid this particular occupational hazard, certain avant-garde "behavior therapists" seem to have the misguided notion that the necessary correction for this early oversimplification is to embark upon a promiscuous rampage down any and every promising therapeutic modality that happens to present itself—all this in the light of "expanding" the horizons of behavior therapy! It is not sufficient to advocate any technique that *subjective* appraisal deems clinically useful regardless of its scientifically demonstrated utility. Furthermore, while keeping an open mind with respect to most techniques, the emphasis should be upon those which emerge out of some behavioral, or at least experimental-clinical, model. Without these necessary precautions, the therapist will be employing not behavior therapy but a nebulous hodgepodge of procedures of varying and largely unknown degrees of effectiveness. The dilution of behavior therapy in this fashion may conceivably make for a colorful armamentarium of techniques, but it is difficult to see how such a practitioner can call himself a behavior therapist.

As the present volume makes clear, it is perfectly possible to go beyond the innovative concepts of distinguished pioneers such as Wolpe without falling into phenomenological and mystical traps. When the psychoanalyst accuses behavior therapy of being simplistic he means that it disregards those hidden unconscious psychodynamic forces that are supposed to be lurking within the individual. In contrast, when the forward-looking behavior therapist says

that certain behavior therapists are simplistic, he means simply that they are naively limiting their approach to the presenting symptom and the straightening confines of the laboratory conditioning paradigm. The challenge to the skillful behavior therapist is to integrate concepts such as cognition and consciousness into the behavioral framework without resort to phenomenology and other besetting devils. While retaining a consistently behavioral framework, he has to adopt a truly functional approach and look beyond the presenting symptom. And, just as Pavlov (if not all of his successors) claimed to be concerned with the principles of higher nervous activity and not merely with conditioning per se, so the modern behavior therapist as well as being a skilled clinician must if the need be look beyond conditioning toward the entire field of experimental clinical psychiatry and psychology. This volume represents one more milestone on the long road to this goal.

While the articles in this book are theoretically sound, they also demonstrate the behavioral sophistication and clinical acumen of the authors. Of particular significance is the inclusion of Gelder's insightful, but all too brief, paper on the indications for behavior therapy. It is most important that behavior therapy be supported by behavioral assessment and, so far, this area of research has been much neglected.

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COMPENSATORY EDUCATION FOR THE DISADVANTAGED

Edmund W. Gordon and Dorey A. Wilkerson, Eds.
 New York: College Entrance Examination Board.
 1966. 299 pp. \$4.50

THE DISADVANTAGED CHILD

Martin Deutsch and Associates
 New York: Basic Books. 1968. 400 pp. \$10.00

We are told often enough of the rapid rate at which the world changes, but a real sense of what that means comes as one

reads these two books, both recent publications, both dealing with work which is certainly contemporary, and yet both having become anachronistic in the short space of time since their publication.

Gordon (no relation to the reviewer) and Wilkerson began by compiling a catalog of the range and variety of compensatory education programs for the disadvantaged, from preschool through university, with programs grouped according to type or, in too many cases, by nature of the "gimmick." The book was written about a time when such programs were springing up in great profusion and variety all over the country. Everyone seemed to be growing his own antipoverty program, free from the necessity of theoretical or empirical bases (everyone knew that the academicians hadn't solved the problem in the past; indeed, much of what they did helped create the problem, so there was nothing the poverty-fighter needed to learn from such sources).

Yet within that frenetic ferment, each program seemed to be about as good as every other one. The authors note that all are reported to be successful, none are proven to be, and one is left with no basis for selecting among them. The result is that the catalog portion of the book is really rather dull reading, consisting of brief characterizations of almost every representative of every type of program then in existence (with acronyms names all recorded, along with the full names and locations of the funding sponsors, etc.). However, despite the detail, the characterizations are too brief to be useful beyond suggesting to the reader the range of possibilities available. Many publications describe innovative programs as if there were a straight line from conception to implementation to realization of objectives. But we know that the line is far from straight, that when systems are revised even in small ways by the introduction of a new program, blood flows and heads are placed on chopping blocks. When one imagines trying out this or that kind of program in his own institution, he immediately begins to wonder how he would deal with the many issues, conflicts, and dislocations that he knows would

arise, and he comes to mistrust the author of the brief report for making it seem too simple when he knows that it is not so, and then he resents the author for not telling him how he handled those problems. In short, the important details (which usually reflect an embarrassing amount of dirty linen) are left out or glossed over, just as teachers often gloss over the seamy details and irregularities of life in their efforts to present a benign, controlled, and ordered world to their children. Most kids know that the world isn't so, and "disadvantaged" kids whose worlds are furthest removed from such an image of rationality, know it sooner. For them, as for the reader of too-brief reports, wonder is replaced by mistrust, and finally by resentment. Those who survive in the system and do well in it are those who are adept at playing along with a gag while they preserve a more authentic self somewhere inside, however they must hide it.

The task Gordon and Wilkerson took on allowed them to do no more than present such capsule summaries, and thus they have fallen into the same trap of making things sound prettier than they are. It would not be fair to fault them for not writing a different kind of book, but it is fair to suggest that while they have accomplished well the purposes of a catalog (and what a huge amount of work that must have been!), its utility would have been enhanced by a closer selective study of representative situations which arise when one tries to implement a new program for the disadvantaged, and how those situations are handled.

This desire for more detail represents one of the ways in which we have become sadder and wiser about compensatory education so rapidly, making the hope implicit in the rich profusion of programs described in the main body of the text seem anachronistic today. And I suspect that the authors experienced some of the same disillusionment, for their last chapter before the 109 pages of appended lists of practices and programs seems much less positive in tone. That chapter is a critique of compensatory education which leads to a questioning of the entire notion of compensation for the disadvantaged. Harry

Passow once cited a "remarkable coincidence": after Sputnik aroused American concern about our failure to provide appropriate educational experience for talented children, and also after the War on Poverty aroused concern with our failure to educate the disadvantaged, the response in both cases was the same: preschool enrichment programs plus more guidance and counseling. The authors of this book come close to the implication of Passow's remark: that when the medicine isn't working, we have had a tendency to simply increase the dosage, and this tendency helps to maintain the status quo in its essential outlines by buying off its more apparent failures. Of course, one could well claim that the only apparent failure of compensatory education for the disadvantaged is a failure to receive sufficient money to really do the job. Yet as long as compensatory education continues to mean special programs and services just for minorities, success will be too marginal to justify massive investment. It will thus continue to be a small scale enterprise, especially as school systems throughout the country outstrip their tax bases. In social and political terms, marginal success is failure. And as failure to buy off the problem with small scale investment becomes frustration, it turns also into anger at those who didn't respond enough, contributing to the growing backlash and turning away from amelioration toward coercion. What is needed, and the only possibility which would not be divisive and discriminatory, is humane education for all kids, in which the poor and the not-so-poor can have common cause.

The authors sketch some of the guidelines of what such an education might be. In their view, it would be one which abandoned the notion of schools as credentialing agents which serve to testify to the amount of knowledge that students have acquired, and replaced it with a view of schools that exist to teach those core skills that will enable students to continually acquire and modify their knowledges throughout life, schools that train people to use knowledge in action, and schools that enable people to fill their leisure in life-enhancing ways. My list of the signifi

cant objectives of education differs from Gordon's and Wilkerson's, but the only quarrel I have with their interpretation of the need for compensatory education as an implicit criticism of noncompensatory education comes from my wish that they had said it louder, clearer, and more insistently.

The authors make a number of important criticisms of compensatory education as it is practiced, but one which I found most interesting was their observation that making teachers familiar with the "culture of poverty" often turns out to be counterproductive. Such familiarity readily turns into a ready excuse for failure (e.g. how can one expect much achievement from a youngster beset by overwhelming problems in home and neighborhood?), into false discriminations and invidious comparisons between disadvantaged and nondisadvantaged (note that it is rather difficult to think of people as "advantaged"), and leads to interventions which place the burden of change on the youngsters. In effect, the view of the disadvantaged as an homogenous type allows schools to draw the line between those students for whose learning the school and its teachers accept responsibility, and those for whom it barely takes responsibility for teaching, much less learning. And that represents no change at all.

It is today's wisdom that we are beyond the hope of salvation through the kind of tinkering which singles out groups for special treatments that become only more subtle ways of continuing old practices under new and more "scientific" rationalizations. It is now widely recognized far beyond the limits of the New Left that when so many individuals seem to be in need of special tune-up jobs, we are in a situation calling for structural-systemic change rather than individual changes.

And in this context, the book by Deutsch and his associates becomes doubly anachronistic. Its first anachronism is the age of the papers which the book reprints (such is the burden of having been among the first in the field), for while they are not old in time, their data and their exhortations have become very familiar to anyone who would listen at all. And it is

anachronistic in its emphasis on disadvantage as something *inside* poor black children.

The Deutsch et al. book is a reprinting of 20 papers, all of which have been published previously or presented at conferences. They cover the work of Martin Deutsch and his wife Cynthia and several colleagues. The papers range from the early experimental work in the late 1950s to the more hortatory writings of the mid-1960s. The papers are grouped into three broad sections, but there is no compelling logic to the groupings or to the ordering of papers within groups. The chapters are verbatim reprints of the original papers; the result is a great deal of annoying repetitiousness, abrupt changes in level of discourse and, because they are not in chronological order, cross-citations which direct the reader's attention to chronologically earlier papers which occur later in the volume, and later papers reprinted earlier in the book.

Most of the chapters are combinations of data-reporting, references to and discussions of the implications of data reported in other papers not included in the book, and calls for action and educational reform. Deutsch's great contribution to the tradition of research on disadvantage was the effort to locate psychological variables which mediate between social status and school achievement. The underlying assumption is that if such focal mediational variables can be specifically modified, more global school performance (particularly reading) will be improved. In a sense, this is a latterday version of old transfer theory, which justified teaching Latin in order to improve English usage. While one may question this assumption (and the reader craves to know whether the experimental training school which Deutsch has run to test this assumption has supported it or not), it is clear that Deutsch has made a contribution by focusing attention on anatomizing gross relationships between social class and academic performance. However, it is necessary to question the very tradition of research on disadvantage, despite Deutsch's exploration of the linkages with which it is concerned.

That tradition, as exemplified in Deutsch's work, is essentially a correlational one in which lower and middle class, black and white, are compared with each other on a number of cognitive skill and trait measures. Those on which differences are found are singled out, and the correlation between those differences and differences in academic achievement among the groups is interpreted as marking a causal or mediational process. In this kind of analysis, it is inevitable that score differences among the groups are interpreted as evidences for deficit in the poor and/or black groups. The better school performance of the white middle-class comparison group is taken to justify using that group's performance on the skill or trait measures as the standard which the underclass must meet in order to succeed in school and in the meritocracy beyond.

Thus one looks in vain for indications that what goes on in schools or fails to go on there, rather than in the child, might also account for academic failure (despite Deutsch's findings in the earliest of the papers which identifies differences between *de facto* segregated black and white schools); one looks in vain for suggestions that some differences between black and white, poor and nonpoor, might represent *assets* and *talents* developed in the underclass milieu that could be capitalized.

For example, the interesting finding that disadvantaged children show poorer auditory discrimination was interpreted as a mediating factor in reading retardation. The relationship between poor discrimination and poor reading became the focus of research and the basis for the expectation that auditory discrimination training should have a salutary effect on reading. This research marks an advance in the sense that it provides Head Start-like programs with something to do that goes beyond providing only sympathy and unguided experience, for which Gordon and Wilkerson justly criticize compensatory projects. But Deutsch's research not only makes the correlational error in assuming causality (which means that he may be providing a false curriculum content for Head Start); in its readiness to interpret difference as deficit, and to examine only

the school failure correlates of the difference, it ignores the possible asset correlates of the difference. While low auditory discrimination may be implicated in poor reading, Deutsch does not consider the possibility that such auditory functioning may also serve as part of what Hemingway praised as a "built-in shockproof crap detector," that from a positive point of view it might function to enable disadvantaged kids to concentrate and perform well in noisy environments by screening out interfering sounds, and that such a skill might therefore be made to function as an asset were the classroom to reward it and see it as a skill required for living in an increasingly noise-polluted urban environment.

For the sake of argument, assume that Deutsch had looked for and found an inverse relation between auditory discrimination and "concentration." Such an assumption provides a model for how racism might work in education: (1) middle-class kids are not facile at screening out competing sound stimuli; (2) therefore teachers try to keep classrooms quiet so that they can concentrate; (3) the school is thus modified to fit the needs of its middle-class students, and at the same time a potential skill advantage of the underclass is rendered useless while the dysfunctional correlates of the same skill potential in the underclass are emphasized; (4) further, the institutional adjustments made to fit the characteristics of the middle-class children are not made for the lower class; in their case it is they who are expected to change to fit the institution, because they are a minority; (5) thus majoritarianism functions to maintain racism. Would it not be just as feasible to make classrooms noisy places, to require middle-class kids to learn to screen out noise so that they can concentrate as well as lower-class kids? In that case, who would be "the disadvantaged"? Does disadvantage lie within people's trait characteristics or in the extent to which institutions are willing to adapt themselves to those characteristics?

The interpretation of differences as deficiencies, the selection, from the array of possible correlates of variables on which

differences are found, of only those which describe disvalued performances, and thus the call for intervention which requires change in the "victim" himself, has stimulated the resentment of blacks who are tired of having their noses rubbed in their "deficiencies." This kind of research allows schools and other institutions to see poor minorities as "special problems"—a continuation of the nineteenth century's white man's burden—rather than as people whose assets can enrich all our lives. Such research lends a scientific justification for compensatory education and to the kind of marginal accommodation without change which palliates but does not cure.

Finally, there is much recent evidence which points to the effect of the measurement situation on subject performance in research. One outcome of this evidence is a realization that the social relationship between subject and researcher modifies subject performance. For example, Ledvinka in an unpublished dissertation finds that the presence of a restricted verbal code which is said (by Deutsch and many others) to characterize the linguistic limitations of disadvantaged children and adults depends on who the interviewer is: black interviewers elicit more elaborated language structure from black job applicants than do white interviewers, suggesting that what had been thought of as some kind of enduring trait in the disadvantaged may really be a more situationally determined response. We do not know from Deutsch's reports who his experimenters were, and thus we cannot evaluate the possibility that the score differences he found between disadvantaged and other subjects may represent differences in how these groups relate to white or black middle-class collectors of research data. The possibilities left open by this unresolved question make it dangerous to assume that score differences represent any enduring response dispositions or capacity limits in disadvantaged children.

The pattern of research and interpretation exemplified by Deutsch's work is a familiar one among liberal psychologists; this reviewer is among the guilty. But many have moved past that stage in the

development of ideas about disadvantage. They have moved to a greater concentration on disadvantaging institutions and events, to examination of the "ego defects" of the majority, and to the psychological processes which mediate between personal and institutional racism and their effects on the majority and minorities.

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THE EMOTIONALLY DISTURBED CHILD IN THE CLASSROOM

Frank M. Hewett

Boston: Allyn and Bacon. 1968. 373 pp.

My first serious exposure to the world of work came as a teacher of emotionally disturbed children. About the only thing I had going for me at the time was youth, ignorance, and a determination to survive at all costs. Nothing in my experience and education had prepared me for this. I sought help from my learned colleagues in education and mental health, from great books, from my puzzling students. I ran eagerly to case conferences with all cerebral and sensory neurons quivering and ready, and came away with much interesting stuff. Every once in a while there was a psychic click that led me to try something new in the classroom. After two years, however, I began to sense that the gap between knowing a person's state of mind and knowing how to help him learn in school were difficult "knowings" to bridge. I also began to sense that emotionally disturbed children were, like other children, action-oriented, competence-seeking animals interested in learning and in learning how to learn. Why not start from this side of the bridge and ask the clinicians to zero in their skills on educational as well as therapy goals? As a teacher responsible for doing something with these children for several hours a day, I—along with my colleagues—wanted some practical ways to think and act about my job.

Hewett has begun that task and crossed some significant bridges along this road. He sees the emotionally disturbed child, including the severely disturbed child, as a learning problem which teachers can do something about other than survive. He suggests that helping a child with a messed up, chaotic, intrapsychic condition is not limited to varieties of psychotherapy. The idea is to find ways of combining tasks, rewards, and structure in learning so that each child can grow into an effectively functioning individual.

First off, Hewett reviews the essence of other strategies for helping emotionally disturbed children—including the psychodynamic-interpersonal, the sensory-neurological, and the behavior modification. He then poses his preference for a school-centered, developmental strategy. He hypothesizes that in order for a child to make it in school (i.e. become a successful and creative learner) he must learn to (1) pay attention, (2) respond to others, (3) follow directions, (4) freely and accurately explore the environment, and (5) learn how to function appropriately with peers and adults. He points out that these are also the goals of other strategies but that teachers have difficulties translating the psychodynamic-interpersonal or the sensory-neurological strategies into classroom goals and practical educational curriculum. Therefore, he asks, why not meet teachers on their home grounds—the classroom.

Each of the stages in Hewett's hierarchy leads on to the next and contains practical suggestions for content-process learning and goal-setting. There are helpful discussions of the concepts of rewards and structure and their employment by teachers of emotionally disturbed children.

Hewett moves with the teacher through each of these stages, translating such terms as autistic, schizophrenic, psychotic, and atypical into educational and school behaviors. All such children usually have severe attention problems. How then does a teacher begin? Examples are given and discussed as the child and teacher move up the learning-competence ladder. This is later amplified in terms of the way it was utilized in the Santa Monica schools.

Hewett is writing as a mediator be-

tween clinician and educator and as an advocate for the teacher of the emotionally disturbed child. He resonates confidence in his approach without appearing to be the purveyor of a new religion or panacea. In fact, he appears to lean over backwards as he does some fancy tip-toeing through and around the professional ivy which has become encrusted onto programs for emotionally disturbed children.

This is one of the few books I know in which teachers of emotionally disturbed children will find some practical help and support. It is also one of the few books on the topic which clinicians can read with profit, whether or not they buy all they read. In any case, they may find it refreshing to pursue a hard-nosed theory and set of practices to help emotionally disturbed children. They may also begin to see how personality theory can be wedded to knowledge about the school as a social system to bridge the gap between clinician and educator.

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COMMUNITY PSYCHIATRY: EPIDEMIOLOGIC AND SOCIAL THEMES

Mervyn Susser

New York: Random House. 1968. 398 pp. \$8.95

This is not just one more book added to the long list of books in the now fashionable field of community psychiatry, describing its theoretical foundations or providing us with descriptions of individual programs. This volume provides the practitioner with a highly readable account of the implications of research concerning the role of social factors in the etiology and community treatment of mental disorders and mental retardation.

The introductory chapter, on the historical evolution and rationale of community care in different countries, is a much-needed reminder that while in the past psychiatrists have failed to give due

weight to the social components of mental disorders at present sociologists sometimes fail to give due weight to the intrapsychic components. It appears to this reviewer that not sociologists alone need to be accused of this failing. A more balanced point of view on everyone's part, stressing intrapsychic as well as environmental forces and not viewing mental disorders solely in terms of disturbed interpersonal relations is needed.

The interaction of patients and society are dealt with by Susser in two chapters, which show the extent to which both institutionalization and successful adjustment after discharge are related to the cultural setting and the type of family from which the patients come. Summarizing the voluminous research in this area, Susser emphasizes that the readjustment of the patient discharged from a mental hospital is more related to the domestic setting of the family and community to which the patient returns than to the severity of symptoms. He compares the discharged patient to the returning soldier who returns to a family which has successfully accommodated itself to his absence. The latter, however, is a hero; the former is stigmatized as a deviant. The schizophrenics who return to a lodging may be better able to stay out of the hospital than the ones returning to parents, who in turn will be more successful than those returning to their wives. The expectations of the environment to the returning patient play a role here. Wives make greater demands on returning husbands than mothers.

In discussing the complex interrelation between patient and family, Susser, commenting on the theories of Bateson, Lidz, and Wynne, believes that at present we are not in a position to state whether faulty forms of family interaction contribute to the development of schizophrenia, or are themselves the consequences of morbid personality.

A strong plea supported by many illustrations is made for the use of research in planning and program evaluation. Epidemiological surveys are needed to establish service needs, operational research to study uneconomic operations.

Registers of incidence and prevalence

provide a useful continuing measure of extent and type of serious illness in different communities. They can demonstrate shifts in the use of services, and help to assess impact of new policies. They can also identify groups in the community who are most vulnerable in psychiatric terms and those who, perhaps for different reasons, make the highest demands on service.

Especially worth reading is the section illustrating the conduct of social experiments evaluating the effectiveness of community care. The author emphasizes the need for spelling out specific objectives of community care. He stresses what is often forgotten—that effectiveness should be measured not only in terms of a reduction of admissions, or number of days in hospital, but in terms of the effectiveness of the new program not only on patient functioning and discomfort but on the families of the patients and the community at large, aiming at a reduction of morbidity. Several chapters deal with the merits and difficulties encountered in different types of intervention (e.g. day care centers, residential community-based centers), discussing types of staff-patient relations. Special emphasis is given to the role of the social worker and the nurse, again concentrating on available research data.

I would have wished that more space had been given to the role of the psychiatrist as well as to patterns of interaction between different disciplines. To some extent this is done in a chapter dealing with the coordination of services in the interest of continuity of care, based in large measure on the author's experiences over a period of several years as the medical director of the mental health services in Salford, England, prior to his coming to this country.

Susser demonstrates dramatically how competition between professions and between agencies often prevents the establishment of integrated services and interferes with the referral of patients to services best equipped to deal with their specific problem. He also shows the extent to which changes in structure and method of patient care are perceived as a threat to various individual mental health work-

the planning and administration of programs, and will be a useful reference book for those engaged in research.

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INTERACTION IN FAMILIES

Elliot G. Mishler and Nancy E. Waxler

New York: John Wiley & Sons. 1968. 436 pp.
\$11.95

Mishler and Waxler are highly sophisticated about theories of family and small group behavior. In this book, they attempt to submit these theories to experimental analysis by describing, in the greatest detail, a study which compares interaction in families containing a schizophrenic member with normal controls. The principal subject is the process by which the authors carried out family interviews and analyzed the data in terms of various conceptual frameworks. Although the task is a noble one, and has been nurtured with the greatest care and attention to detail, I do not feel that Mishler and Waxler have succeeded in their purpose. This raises some serious questions about this type of work in general. To what extent will it ever be possible to submit clinical concepts to research scrutiny without altering the concepts studied to such an extent that they become unrecognizable by the clinician? Although the authors have been scrupulous in their work, there are still major flaws which make it difficult to accept the validity of this study.

The 49 families studied contain either a schizophrenic with a poor premorbid history, a schizophrenic with a good premorbid history, or a "normal" control recruited through a school or church. Two parents and the index case are brought to the laboratory where they are given a structured procedure to stimulate discussion (Revealed Difference Technique). The process is later repeated with the parents and a sibling. Transcripts of these discussions provide the data by which

family interaction is analyzed. The authors carry out a "microanalysis of verbal behavior" using eight different codes ranging from "affect" to "fragments." Different items from these codes are clustered together to form five conceptual areas by which comparisons between the different groups are made. The areas are expressiveness, strategies of attention, person control, speech disruption, and responsiveness. There is an abortive attempt to relate aspects of these conceptual areas to clinical concepts such as "double bind," "pseudomutuality," and "marital skew and schism." The findings are generally too complex to be discussed in this review although one interesting observation is that disruptions are more common in normal families than in the families of schizophrenics.

The processes of sampling, interviewing, transcribing, coding, and analysis are described in impeccable detail. This enables the reader to form his own conclusions about the validity of the study. Unfortunately, I was disturbed by a number of methodological flaws.

The assessment of schizophrenia, based on a diagnosis made by treating psychiatrists at the Massachusetts Mental Health Center, must be seriously questioned. The type of "schizophrenic" admitted for intensive therapy at a training hospital is frequently diagnosed as borderline or neurotic in other localities. Schizophrenia is such a vaguely defined term, these days, that the researcher must specify more precisely what he is attempting to study. The controls are purported to be a sample of "normals" and the authors make a point of stressing that this is not a neurotic sample. The criterion for calling these controls "normal" is the absence of psychiatric hospitalization. This is unfortunate in the light of demographic studies which have indicated that perhaps 80% of the population experiences psychiatric symptoms at some time or other. Also, 58% of the control families contacted refused to participate in the study. This makes me wonder whether the 42% who participated were skewed in the direction of greater pathology or greater normality. A clinical evaluation of these families would have been very helpful. Although the authors

acknowledge that they picked a narrowly defined sample of white, intact families, the inclusion of blacks and an analysis of social class would have been most interesting.

The analysis of the data leaves me somewhat puzzled. The authors indicate that they are only attempting to show trends and indicate that significance at the .20 level is adequate. I could accept this strategy in theory but it does not work out in practice. For example, the chapter on "Expressiveness" contains 408 statistical comparisons: 17% are significant at the .20 level, 8% at the .10 level, 4% at the .05 level, and 0.5% at the .01 level. It is my understanding of this type of analysis that, if one had arranged the data randomly, there would have been a greater number of "statistically significant" items. Perhaps if statistical tests were applied to groups of items, the results would have been more satisfactory. Still, it is unclear which findings represent valid trends and which are the result of coincidence.

My greatest reservation about this type of study is anticipated by Mishler and Waxler, on page 273. "Clinicians often argue, particularly when research findings are not in accord with their observations, that researchers—by emphasizing precision, reliability, objectivity, and quantification—define the basic clinical problems out of existence." They appeal to the clinician for more precise terms but I believe that the authors have attempted such a high degree of precision, that they have lost the forest for the trees. The finding

that "normal" families are more disruptive than schizophrenic families is a case in point. Disruptive behavior is characterized by analyzing items such as laughter, pauses or incomplete sentences. Since most conversation characteristically contains these elements, they would hardly seem indicative of the type of disruption a clinician is talking about when he describes a schizophrenic family. Singer and Wynne¹ circumvented this difficulty by developing research concepts which are more directly relevant to clinical situations, while still maintaining a high degree of precision in their research methodology.

The preface indicates that this book is part of a series in psychology for practicing clinicians. I do not think that clinicians will enjoy this book unless they have a particular interest in research methodology. Even for the devotee of research, this book is written in an abstruse style which makes it extremely difficult to read. Nevertheless, this is an important study and should be of interest to all investigators concerned with social phenomena.

REFERENCE

1. SINGER, M., AND WYNNE, L. 1965. Thought disorder and family relations of schizophrenics: IV. results and implications. *Arch. Gen. Psychiat.* 12:201-212.

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MENTAL HEALTH HIGHLIGHTS

by Jack Wiener

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No More Residence Requirement

In a far-reaching decision, the Supreme Court ruled that residence requirements in all federal public assistance programs are unconstitutional. As a condition of eligibility for assistance, states are prohibited from imposing durational residence requirements that exclude any person who lives in the state. Residence requirements violate the "due process" clause of the Fifth Amendment and also the "equal protection" clause of the Fourteenth Amendment of the Constitution.

SHAPIRO V. THOMPSON, *U. S. Supreme Court*
Nos. 9, 33, 34, April 21, 1969.

For Children

A new Office of Child Development has been established in the Secretary's Office of the Department of Health, Education, and Welfare. The new office will "serve as a point of coordination and advocacy for children's programs conducted by H. E. W. It will also operate Head Start and day care programs."

The Young Left

Student demonstrators in England and France in the past year came up with these slogans:

- Be realistic: demand the impossible
- I am a Marxist: with Groucho tendencies

- We are all foreign scum
- Pigs out—students in

RICHARD BOSTON, *Firebrand X. New Society*,
332:212, February 1969.

Life on the Welfare

You can get some idea of what it means to live on public assistance from the preliminary findings of a 1967 nationwide study conducted by the federal Social and Rehabilitation Service.

Mail questionnaires were sent to a representative sample of 3,659 mothers receiving Aid to Families with Dependent Children. Responses were received from 2,969 women—a return rate of 81%. The women's responses added up to the following:

- Nearly half said that there were some times in the previous six months when they didn't have money to buy milk for their children. Over one-third delayed paying the rent to buy food.
- A large majority of the families had inside running water, the use of a kitchen, a bathroom with shower or tub and a flush toilet. Half had their own telephone.
- Thirty percent did not have enough beds for everyone in the family. One-fourth didn't have sufficient furniture for the whole family to sit down together for a meal.
- In 1 out of 6 families, a child stayed home from school at times because of lack of clothes or shoes.

- Forty percent needed but couldn't afford to go to a dentist in the previous six months. About a fourth needed but couldn't get eyeglasses, and a fourth didn't go to a doctor when they thought they should.
- If their welfare money could be increased, about half the mothers would spend it first for food. About one quarter would give priority to clothes and shoes.
- Forty-five percent of the mothers had received public assistance for more than 3 years.
- About 7% said that their welfare workers had helped them by "social or emotional support."
- Over 40% of the mothers had not gone further than the eight grade in school.

National Center For Social Statistics. Social and Rehabilitation Service, U. S. Department of Health, Education, and Welfare. 1967 AFDC Study—Preliminary Report of Findings From Mail Questionnaire, January 1969.

Up & Down Pills

Two national interview surveys in 1967 found that one out of four U. S. adults took a psychotropic drug in the previous year. For the surveys, the Social Research Group of George Washington University defined the psychotropic drugs to include sedatives, tranquilizers (the "down" drugs), and stimulants (the "up" drugs). Narcotics and psychedelic drugs were excluded. Most of the psychotropic drugs are prescribed by general physicians.

Sedatives and tranquilizers are much more widely used than the stimulants. But the 18–20 year old group took more stimulants and less sedatives than the group over 21 years of age. Young adults "apparently want to wake up rather than go to sleep."

Many more women use the psychotropic drugs than men. Jews are in the high-use group; Negroes are in the low-use group.

This study made me wonder whether there is something wrong with our mental health or is it only psychological?

HUGH J. PARRY. *Use of Psychotropic Drugs by U. S. Adults. Public Health Reports, 83(10):799–810, October 1968.*

State Legislation

1969 has been a relatively quiet year for state legislation on mental health. But many states passed laws providing penalties for race riots, student disturbances and drug abuse. On the positive side, the following new laws are worth noting:

- In Connecticut, homosexual acts of consenting adults in private are no longer a crime. Connecticut is the second state to approve such a law. (Illinois passed the first law in 1961). You can expect more states to pass such a law in the future.
- Arkansas, Delaware, Kansas, and New Mexico passed "liberal" laws which permit therapeutic abortions.
- Nebraska and Wyoming joined the Interstate Compact on Mental Health. The Compact is a cooperative interstate agreement which permits a state to provide hospital care, treatment and after care to mentally ill and mentally retarded patients, even if they are legal residents of other states.
- Oklahoma became the 33rd state to pass a community mental health services act which authorizes state grants to localities for local mental health services.
- Georgia modernized its law on the admission and discharge of mental patients. The new law has a "bill of rights" for patients. The law emphasizes voluntary methods of admission, rather than commitment.
- Maryland reorganized to establish a new Department of Health and Mental Hygiene, combining the former Departments of Health, Mental Hygiene, and Juvenile Services. Maryland also revised its State Community Mental Health Services Act to abolish the local contribution. No local matching will be required even though services will be locally administered.
- Wyoming established a new State Department of Health and Social Services which includes the State community mental health program. The mental hospital and institution for the retarded are not in the new Department.
- Following the South Carolina model,

Arkansas established a separate State Department of Mental Retardation.

Treat or Pay Damages

A State mental hospital patient who doesn't get treatment may now be able to collect large money damages from the State. In the case of *Witree v. the State of New York* (1968), the Court of Claims of New York awarded \$300,000 to a patient who had been committed to the Matteawan State Hospital.

Mr. Whitree entered the hospital in 1947 following a charge of third degree assault with a knife. At the time of his confinement he was diagnosed as having a "paranoid condition with chronic alcoholism." He was kept in the hospital for 14 years until 1961 and filed suit after his release.

The court ruled that the treatment given the patient was grossly inadequate and that the custodial care in part was "brutal and callous." The court decided that with proper psychiatric treatment the patient should have been discharged from the hospital within two years. Therefore, he was falsely imprisoned for the remaining twelve years. A large part of the damages was based on his loss of earnings during that period.

Until this case, a few courts used the concept of "the right to treatment" to release committed patients. But if the Whitree case is affirmed and followed by other courts, then States that fail to provide adequate treatment may have to pay a lot of money in damages.

Will that lead to larger State appropriations and better staffing for mental hospitals? Or, will it simply mean that untreated patients who are still sick will be quickly discharged from the hospitals?

WILLIAM J. CURRAN, *The Right to Psychiatric Treatment*, *American Journal of Public Health*, 58(11):2156 & 2157, November 1968.

Hold Me

"I do like to be held and especially at night when it's time to go to sleep." That's what one of the women said in a study of

the need or desire for body contact. Another woman said about the desire for body contact, "It's a kind of an ache . . . it's a physical feeling." The investigators believe that when adult women are held or cuddled, it may reduce anxiety, promote relaxation and a feeling of security, and provide a distinctive type of gratification.

The subjects were 39 women patients of the psychiatric service of the Hospital of the University of Pennsylvania. All were admitted for acute disorders, mostly neurotic depression. They were between 18 and 59 years of age, had completed at least 11 grades in school, and were or had been married.

Through a self-rating questionnaire and interviews, it was found that more than half of the entire group had used sex to entice a mate to hold her. Twenty-six patients had directly requested to be held. For some women, sexual activity was a price to be paid for being cuddled and held. Also, the desire to be held seemed to be an important determinant of promiscuity.

The sample and the research design in this study are not the greatest, but there is a novel and perhaps important idea here. But why assume that the desire to be held is limited to women? What about men?

MARC H. HOLLENDER, LESTER LUBORSKY, AND THOMAS J. SCARAMELLA. *Body Contact and Sexual Enticement*, 20(2):188-191, February 1969.

Black and White

Which are more frequent, marriages of Negro men to white women, or marriages of white men to Negro women? Most studies have shown that marriages of Negro men to white women are more frequent. But a recent analysis of 1960 Census data revealed that marriages of white men to Negro women are just as frequent as marriages of Negro men to white women. Lewis F. Carter, the investigator who analyzed the Census data, believes that previous studies were biased because they were based on data from large urban areas in the Northern and Western regions of the

country. The Census data include rural areas and all regions of the country.

LEWIS F. CARTER. *Racial-Caste Hypogamy: A Sociological Myth?* *Phylon* 29(4):347-350.

Women Report More Psychological Complaints

In the town of Lebanon, New Hampshire, which has a population of 9,000, two investigators, Phillips and Segal, interviewed a random sample of 278 men and women. The subjects were all married and between 21 and 50 years old. They were asked about their physical illnesses and also were given the 32-item Mental Health Inventory used in the Midtown Manhattan epidemiology survey of mental disturbances.

As in other studies, it was found that more women had high scores on the Mental Health Index than men. More than 1/3 of the women had a high score compared to 1/5 of the men. But when the Index was broken down into types of items, it was found that the increased frequency of high scores of women was primarily on the psychological items, whereas on physiological symptoms (like fainting or poor appetite) slightly more men had high scores than women.

Examination of the data on the number of physical illnesses showed no differences between men and women. For both sexes, the greater the number of physical illnesses, the greater the percentage with high scores on the Mental Health Index. The authors conclude, "Women are more likely than men to report feelings and be-

havior that are seen as signs of psychiatric disturbance."

In regard to utilization of medical services over a one-year period, examination of medical records (from a hospital, clinic and private physicians) revealed that more women than men sought medical help. Surprisingly, when sex and the number of physical illnesses were held constant, there was no relationship between any of the measures of psychiatric symptoms and the use of medical facilities.

The authors believe that because of cultural reasons, men have a greater reluctance than women to admit unpleasurable feelings.

DEREK L. PHILLIPS AND BERNARD E. SEGAL. *Sexual Status and Psychiatric Symptoms.* *American Sociology Review*, 34(1), February 1969.

Forbidden Fruit Is Sweeter

Denmark has abolished all legal penalties against pornography for adults beginning July 1, 1969. For several months before July, existing laws on pornography were not enforced so that there was no restriction on pornography in magazines, books, pictures or films for any person over 16 years old.

Since pornography has been freely available, sales of pornographic materials have dropped sharply. Police report that sex crimes have decreased or at least have not increased. Denmark's law still makes it a crime to sell pornographic materials to children under 16 years of age.

Time, June 6, 1969.

BUSINESS MEETING

The business meeting of the American Orthopsychiatric Association convened on Sunday, March 30, 1969 at the New York Hilton Hotel, New York, New York, with Dr. Dane G. Prugh, president, presiding.

Motion was made and seconded that the minutes of the 1968 business meeting as published in the October 1968 issue of the *American Journal of Orthopsychiatry* be approved. Motion passed.

DECEASED MEMBERS

Silent tribute was paid to the members who had died during the year:

Carroll, Clara, M.A.	1942	Marshall, Marion G., M.D.	1960
Frank, Lawrence K., LL.D.	1932	Richie, Richard F., M.D.	1939
Grish, Albert J., M.D.	1964	Ritey, Hector J., M.D.	1948
Hertzman, Jack, M.D.	1939	Shugart, George, M.A.	1955
Hincks, Elizabeth M., Ph.D.	1932	Thomas, Edwina T.	1955
Jungreis, Jerome E., M.S.	1967	Tibout, Nelly H., M.D.	1940
Kaufman, Lawrence, Ph.D.	1961	Weinstein, Leonore K.	1967
Lloyd, Ruth, M.A.	1943	Wheeler, Doris P., M.D.	1949
Luckey, Bertha M., Ph.D.	1931		

LIFE CERTIFICATES

President Prugh awarded Life Certificates to 27 members of the Association, who have been members since 1939:

Fanny Amster, M.S.W.	E. Louise Gaudet, Ph.D.	Harriet E. O'Shea, Ph.D.
Harold H. Anderson, Ph.D.	Ethel L. Ginsburg	Harry N. Rivlin, Ph.D.
Herbert H. Aptekar,	Harold B. Hanson, M.D.	Frederick J.P. Rosenheim,
D.S.W.	Lucia M. Irons, M.S.	M.D.
Frances S. Arkin, M.D.	Richard L. Jenkins, M.D.	Helen Ross, M.S.
Abram Blau, M.D.	Morris Krugman, Ph.D.	Exie E. Welsch, M.D.
Jules V. Coleman, M.D.	Joseph Lavallee, M.D.	Ernst Wolff, M.D.
Marian A. Despres, Ph.D.	Olga R. Lurie, Ph.D.	Adolf G. Woltmann, M.S.
Eugene I. Falstein, M.D.	Marian F. McBee, M.S.W.	Susan B. Woods
Greta Frankley, M.D.	Ruth Mellor	

NEW OFFICERS

Dr. Michael Newman reported for the Tellers the result of the mail ballot for the president-elect, vice president, and secretary of the Association for 1969-70. Elected were: Benjamin Pasamanick, Ph.D., president-elect; Eli M. Bower, Ed.D., vice president; Max Deutscher, Ph.D., secretary.

RESOLUTIONS

Dr. Newman also reported the result of the vote on a resolution submitted to the membership during the year:

RESOLUTION ON CIVIL DISTURBANCE AND VIOLENCE

Proposed by the Committee on Mental Health Aspects of Aggression, Violence, and War. Total membership ballot 1,221—approved 916 to 304, one abstention.

The Association believes that civil disturbance and violence are not properly met by repressive measures. Unjustified use of a repressive measure, such as a court injunction against public meetings, use of anti-riot weapons, or a police rout, has several effects which should be noted: (1) It increases the frustration and the inclination toward more extreme behavior by the victims, (2) It makes the remaining public and the law authorities more dependent upon coercion to exercise control, (3) It eliminates full exploration of the issue by the public.

Each use of anti-riot weapons or massive display of force against civilians: (1) reduces respect for legitimate authority of law enforcement on the part of all civilians, (2) generates a desire for violent retaliation by the victims, (3) dehumanizes the law officer by making him callous to the suffering of victims and less willing to rely upon his own persuasion and authority, and (4) violates due process by making the enforcement officer the judge, jury, and punishing agency in one. This motivates individuals to forsake the law which no longer appears to afford them constitutional guarantees.

The Association recommends that these repressive sanctions be weighted against alternative measures. Among such alternatives would be: (1) more serious attention to the causes of unrest and persistent efforts to cope with its basic causes, (2) respect for the great demands of protesters and comprehensive measures to deal with them quickly and directly, (3) increased effort at police and civil authority education in nonviolent options for crowd control, (4) stricter control over the conditions of the police use of any weapons, and (5) orderly procedures of arrest, and restraint in the use of force.

NEW FELLOWS

The following Fellows, proposed by the Membership Committee and approved by the Board of Directors, were elected by a very large vote:

Archibald, Charles W., Jr., M.S.W.	Finkelstone, Berenice G., M.S.W.	Hassler, Ferdinand R., M.D.
Black, Morris, M.S.S.	Fox, Ann Q., M.S.W.	Heacock, Don R., M.D.
Boverman, Harold, M.D.	Gibson, Guadalupe, M.S.W.	Icc, John F., M.D.
Bowes, Anne E., Ph.D.	Girshman, Karl M., M.S.S.A.	Ichikawa, Alice Y., M.A.
Braen, Bernard B., Ph.D.	Graham, Stanley R., Ph.D.	Illing, Hans A., Ph.D.
Brown, Bertram S., M.D.	Gumrukcu, Patricia, M.A.	Jenkins, Shirley, Ph.D.
Butts, Hugh F., M.D.	Hagest, Robert J., M.S.W.	Kraemer, Doris R., Ph.D.
Combier, Lindell, M.S.W.	Ham, John P., M.S.W.	Lieberman, Janet E., Ph.D.
Christ, Adolph E., M.D.	Harari, Carmi, M.A.	Lucas, Alexander R., M.D.
DeBaggis, Anthony, Jr., M.S.W.		Malmquist, Carl P., M.D.
		McKinney, Leon R., M.D.

Minuchin, Patricia P.,
Ph.D.
Munzer, Jean, M.D.,
Ph.D.
Northrup, Gordon, M.D.
Pancost, Richard O., M.S.
Pearce, Patricia R., M.D.
Price, John M., Jr., M.D.

Raffe, Irving H., M.S.
Ritvo, Edward R., M.D.
Schomer, Jesse, M.D.
Schwaab, Edleff H., Ph.D.
Shaw, Orla M., M.S.W.
Smith, H. Carlton, M.S.W.
Smith, Richard M.,
M.S.W.

Snyder, Phyllis R., M.S.
Sugar, Max, M.D.
Wagner, Nathaniel N.,
Ph.D.
Waldo, Leslie C., Ph.D.
Werry, John, M.B., Ch.B.

NEW MEMBERS

The following new members were elected:

Abelson, Edna R.,
M.S.S.W.
Allen, Layman E., LL.B.
Allender, Edith, M.A.
Anderson, A. Scott, Jr.,
M.D.
Anshin, Roman N., M.D.
Argy, William P., Sr.,
M.D.
Armstrong, Glenn D.,
M.A.
Bach, Perry B., M.D.
Barclay, Louzelle,
M.S.S.W.
Behrle, Frederick J., Ph.D.
Berenson, Gerald, Ph.D.
Bergeron, James A., Ph.D.
Birchard, Carl, M.S.W.
Blanco, Antonio M.,
M.S.S.W.
Bloom, Lillian, M.Ed.
Bouhoutos, Jacqueline
C., Ph.D.
Brashares, Charles,
M.S.W.
Brauzer, Marianne D.,
M.S.
Broadus, Susan L., M.A.
Brooks, Mary, M.A.
Browne, Thomas H., M.S.
Bruce, Constance, P.,
M.S.W.
Burke, Maurice O., Ph.D.
Burlingham, Carlos E.,
M.D.
Burns, Harriet, M.S.W.
Bussell, Robert E., M.D.
Byron, Leonard J., Ph.D.
Cappas, Andrew T., Th.D.
Carrera, Frank, III, M.D.

Ceithaml, Carol, M.A.
Chafetz, Morris E., M.D.
Chen, Ronald, M.D.
Christ, Jacob, M.D.
Church, Edwin H., M.D.
Cifu, Robert, M.D.
Clancy, Mary F., M.S.W.
Cline, David W., M.D.
Clinebell, Howard J., Jr.,
Ph.D.
Colvin, Arthur M., M.D.
Comer, James P., M.D.
Crary, Gerald C., M.D.
Delany, Frances I., Ph.D.
Deletra, Marie, M.S.W.
Demsch, Berthold, Ed.D.
Dennis, Everette E., M.A.
Dightman, Cameron R.,
M.S.W.
Dincin, Jerry, M.S.W.
Doernberg, Nanette L.,
M.A.
Drechsler, Ethel W.,
M.S.W.
Duff, Willard E., M.S.W.
Duffy, John C., M.D.
Dukette, Rita, M.S.S.
Eisenberg, Joann R., M.A.
Ellison, David L., Ph.D.
Fallon, Cecile W., M.S.W.
Fancher, Edwin, M.A.
Feiner, Arthur H., Ph.D.
Flack, Hannah F., M.S.W.
Ford, Edna K.
Forman, Marc A., M.D.
Fowler, Manet, Ph.D.
Fredlund, Cachel, M.A.
Friedman, Alma, M.S.
Friedman, Gertrude R.,
M.S.S.

Friedman, Theodore I.,
M.A.
Furman, Sylvan S., M.A.
Gaitz, Charles M., M.D.
Galbraith, Jill N., M.S.
Gates, Maurice, Ed.M.
Gatti, Frank M., M.D.
Geigner, Robert D.,
M.S.W.
Gewisgold, Herman A.,
M.S.S.
Gilberg, Arnold L., M.D.
Gladden, William H.,
M.S.W.
Goates, Delbert T., M.D.
Goldman, William, M.D.
Gordon, Arlene R., M.A.
Gottlieb, Frederick, M.D.
Gottsegen, Gloria, Ph.D.
Graham, Juanita K., M.S.
Green, Goldie, A.M.
Griffin, Carol Lee, Ph.D.
Gross, Georgia P., M.S.W.
Gundling, Frank, M.S.S.A.
Hawkins, Alexander A.,
M.S.W.
Hayden, Benjamin S.,
Ph.D.
Heaps, Ann L., M.S.W.
Henrichsen, Bernard H.,
M.A.
Higgins, Dorothy E., M.A.
Hildebrand, Richard J.,
M.A.
Hill, Esther L., Ed.D.
Hoffman, David L., M.A.
Hornsby, Lawrence G.,
M.D.
Hrnchiar, Andrew, M.D.

- Humphrey, Frederick G.,
Ed.D.
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REORGANIZATION

A proposal for reorganization of the committee structure of the Association was distributed to each member present. Dr. Irving Philips, chairman of the Board's Subcommittee on Reorganization, presented background and commentary on the proposal:

At the present time, there are 19 committees and task forces working to carry out the Ortho purposes—to unify and provide a common meeting ground for those engaged in the study and treatment of human behavior problems and to foster research and spread information concerning scientific work in the field. These committees often have difficulty relating to the Board and the membership at large. Over the years, the complexity of the organization has increased considerably, and as it has, the staff work needed to support committee work has become more and more difficult. For this reason, the first proposal is that Ortho begin to enlarge the size of its professional staff to facilitate the work of the Board and the committees. A second problem was that some of the current committees did a great deal of work, others less; that some had well-defined goals, others had none at all; some had become study groups going on almost in perpetuity, others had almost gone out of existence once their original specific goal had been achieved. The work of all the committees, however, tended to fall into four areas: administration; communications and education; social issues; and research and services. Therefore, the second proposal is that the standing committees of the Association—in addition to the Board of Directors, Executive Committee, Nominating Committee, and Journal Editorial Board—be reduced to five, one for each of these four areas plus a fifth on minority group problems because of the relevancy of its current task in light of social reality:

PROPOSED STANDING COMMITTEES

1. Administration Committee
2. Communications and Education Committee
3. Social Issues Committee
4. Research and Service Committee
5. Minority Group Problems Committee

The chairmen of each of these standing committees would be an ex officio member of the Board. Task forces and study groups could be set up and retired by these committees consistent with the kinds of tasks they felt they were able to tackle, with the staff time available, with the issues that were pertinent for the Association at particular times. Members of the standing committees as well as members of their task forces and study groups could all meet together with the Board once a year to form a group within the Association for discussing Ortho overall, thus providing greater cross-fertilization within the membership. Members of the proposed new standing committees would be determined as committee members now are—appointed by the President, with the approval of the Board of Directors. During the transition from current to new committee structure, chairmen of present committees would be made members of the relevant new committees so that ongoing active projects could continue undisturbed.

Response of members present to Dr. Philips' report was focused primarily on the second proposal, reorganization of committees. However, one speaker from the floor stated that he felt the first proposal, enlargement of staff, was critical because only when this had been done in the past had the Association's activities been forwarded and broadened. In answer to a request for more details of the Board's thinking on this proposal, Dr. Prugh reported that the Board was considering many possibilities within the limits of Ortho's financial resources: new staff as liaison between committees and central office was one possibility; setting up an office in Washington to inform membership on legisla-

tive issues and coordinate response to them was another. To help the Board in its thinking, Dr. Prugh reported, Ortho had contracted for the services of a systems consultant firm, Arthur D. Little of Cambridge, Mass., to study Ortho and make recommendations as to how we might improve efficiency and effectiveness within the organization.

Comments of members about the committee reorganization had mostly to do with the format of the specific five standing committees proposed. Why, for instance, are Minority Group Problems and Social Issues separated while Research and Service are combined? Does this not seem to be based on the situation in the past rather than on an evaluation of the future? Doesn't the proposed format go beyond mere administrative questions and raise philosophical and professional questions about the direction the organization is taking?

Dr. Philips and Dr. Prugh explained variously that the Board had discussed these issues long and hotly. The format now proposed is simply a reflection of the Board's judgment and concern at this time. It is not intended to be inviolate but something that would be flexible and change as the Association changes or as issues change. Certainly it is not the intention of the proposal to underplay Ortho's emphasis on Research by putting it together with Service. The Board saw Research as having important implications for Education, and Social Issues, and Minority Group Problems. The thought was that issues in the areas of Research and Service would stimulate each other and that the new combined committee would be in a position to feed issues to the other committees. As to keeping Minority Group Problems separate from Social Issues, the Board felt that racism and the evils thereof, as the most urgent problem of our time, was sufficiently compelling to warrant a committee set up to address itself to that problem alone, for as many years as conditions in our society require.

Dr. William Soskin, chairman of the Organization-Reorganization Committee that prepared the original report from which the present proposals grew, summarized the discussion by pointing out that Ortho had been reorganizing throughout its entire history as problems changed, and that the particular format of the committees in the new proposal was not nearly as important as the inherent element of flexibility. Any administrative structure should be intended only to expedite the business of a group in the particular period in which it finds itself. A continuing process of reorganization is a good thing, for structure must change as goals and purposes change. In fact, the Membership Committee report that is the next item on the agenda of this Business Meeting may raise such fundamental questions about the purposes of the Association that we will have to reshape our whole administrative structure once the membership questions are settled.

MEMBERSHIP

Dr. Prugh presented the background of the Membership Committee report: At the joint Board-Committee Meetings in October 1968, it became clear from the discussions that Ortho should address itself in some way to the problems of the emerging groups of people working in mental health programs. The Board therefore asked the Membership Committee to work out a change in the Bylaws that would provide some category of membership for nontraditional workers and for students in the traditional disciplines, with requirements and fees adjusted to enable these increasingly important groups to be eligible to join AOA. The Board was thinking in terms of an Associate Membership which would be entitled to all privileges, with orderly progression to Full Member and then Fellow status. Because of its lack of capacity to predict just what kind of "non-traditional professional" workers would be interested in associating with Ortho, the Board thought perhaps Ortho could wait until after it had had a couple of years experience with persons who did apply to be Associate Members before developing specific provisions for progression in membership status. The Board recognized that there are

no other organizations to which many of these workers can turn at the present time, and simply felt that Ortho must develop some way of offering ongoing education and inter-professional stimulation to them. The proposals developed by the Membership Committee turned out to be not totally congruent with the Board's initial thinking, which highlights the fact that we are grappling with an important problem and that there are a number of ways of approaching it.

Dr. James Toolan, chairman of the Membership Committee, spoke to the report (copies of which were distributed to members present). The Membership Committee, he said, understood fully that a change in the membership requirements for this Association would be a far-reaching one for great good or great disaster, depending on how it is done. Whatever decision the organization makes should not be an impulsive act but should be based on a clear understanding of what the organization is today, what its image of itself is, what it wishes to be in the future. There are many issues involved. Do we want to be an interest group, like the mental health associations? Or do we want to remain a professional, elite group? How do we envision Associate Members being selected? What will their function as members be? Will they consider themselves second-class citizens? If the question as to what Ortho wants to be and what it wants to accomplish were answered, the Membership Committee could have drawn up membership provisions with little difficulty. As it was, the committee had to answer the fundamental questions its own way as it studied three categories of possible new membership:

1. *Invited Members*—distinguished professionals who lack required credentials. The Membership Committee strongly recommends that this category be reinstated.

2. *Student Members*—students in traditional disciplines. The Membership Committee was somewhat negative about this category, but only because of the complexities. What level of student would be eligible? On-the-job and training? Graduate student? Undergraduate? After how many years of study does one cease to be a student? Five, six, ten years? What would students gain by being members that they don't get now? The only valid reason for student membership the committee could see was that Ortho might in some way be able to encourage students to enter fields we think important.

3. *Associate Members*—nontraditional professionals engaged in the process and delivery of mental health services. The Membership Committee agreed that the greatest problem of establishing such a membership category would be to define what a mental health service is. The committee itself felt that the umbrella should be opened to cover all involved—from lay members of agency boards to architects, economists, political scientists, politicians. At the same time, the committee was strongly opposed to turning Ortho into purely an interest group without any professional standards. Therefore two organizational models were selected for study—The American Association for the Advancement of Science and the American Public Health Association. Both were chosen because they have very large memberships yet have remained vital professional organizations:

- The AAAS is made up of affiliate groups, with a small number of members called Fellows running the central organization, selecting the directors and editors, and enabling the association to keep up high standards in its publications and meetings.
- The APHA is organized in sections. Anyone interested may belong to a section or may join the APHA directly as an individual. But only Fellows can hold office, be appointed to committees, etc. To be a Fellow, a member must have belonged for two years and shown demonstrated ability in his field. About 20% of the total members are Fellows.

Although the Membership Committee did not want to commit itself to any particular model, it did feel the APHA structure should be considered by Ortho as a possible way of opening out to Associate Members. Nontraditional professionals could join Ortho through sections—perhaps a Community Mental Health Section, a School Personnel Section, and a Residential Care Section—and from such a base could then evolve into Full Members and Fellows.

Because this is one of the most important issues ever to face the organization, Dr. Toolan concluded, the Membership Committee prepared its report to be provocative and to lay out alternatives rather than as a firm recommendation.

Discussion of the report from the floor was long and intense. The great majority of speakers agreed that the basic fact of the future was that more and more nontraditional professionals will be working in the mental health field and that there is no more justification for excluding them from a multidisciplinary organization concerned with mental health issues than there would originally have been for excluding any of the disciplines now represented. The issue for Ortho, they thought, was not *whether* to admit nontraditional professionals to membership but *how* to do it without vitiating our standards.

Some members, however, argued that they did not believe that membership could be broadened without inevitably weakening standards. The American Orthopsychiatric Association now carries a tremendous weight not because of the triumvirate membership we have but because of the high standards we have for our membership. To lower qualifications would be a regressive step. Some psychology associations are actually moving in the opposite direction, trying to upgrade the competence level of their memberships so as to carry more authority with the public.

The question was raised as to what function Associate Members would have in Ortho. How could they avoid being second-class citizens if they are to belong to sections? In answer, it was suggested that the sections could have great impact through resolutions, special reports, protests—bringing to the rest of the membership a different orientation to patient care, bringing in the attitude of the community and a knowledge of patients' lives.

A number of members pointed out that whatever Ortho has been up till now, it has never been a professional society. Psychiatrists have their professional societies, psychologists theirs, social workers theirs. These are the guilds that establish professional standards. What Ortho has always stood for is the team approach, recognition of the unique contribution that each discipline has to make. We have been the place where all people who serve the customer in the mental health field come together to communicate with one another. How can we go any other road but to include all the members of the team? Not too many of the nontraditional professionals have their own societies yet, but there will increasingly be more. Ortho could influence these new groups toward high standards by the qualifications we set for our Associate Members and the strength we contribute to their training.

The Committee on Community Mental Health Centers reported that it had arrived at an approach different from that of the Membership Committee. Because it feels that Associate Membership would in fact tend to be second-class citizenship, it is proposing instead that nontraditional professionals be made immediately eligible as Full Members. Suggested qualifications for membership: full-time paid employment for three or more years in the performance of mental health services; training for at least two years and that training certified by the employing agency and its director; the applicant endorsed by three Ortho members [the current requirement for all members] to the effect that he is qualified to make a contribution to the organization. This committee believes that it is even more important to look at the kind of life these workers could bring to Ortho than at what we might be able to do for them.

Complaints were lodged that thinking about the problem in terms of what "they" can do for us and what "we" can do for them led to thinking in terms of human worth, of people of more or less dignity. This polarizes us into positions that make everybody uncomfortable and really does not go to the heart of our concern. The purpose of Ortho has always been the advancement of mental health. In past decades the major need was to develop channels of communication and to promote research and to create an environment in which three major disciplines could get together and talk. Ortho has worked at that task most successfully. But that it is not the pressing need today. Perhaps the whole definition of the American Orthopsychiatric Association needs to be changed. Perhaps the purposes written into our constitution are not ones that are suitable for 1969 and the years ahead. The fundamental nature of Ortho must be determined before the membership question can be settled. We must decide whether the emphasis is to be on social action or on research and service. Do we want to be an association for the advancement of mental health or a scientific forum in which to have intensive discussions of professional interest?

One member suggested that Ortho could take as a new purpose the solving of a major problem growing in the mental health field. Everyone involved in mental health services today faces the question of how to achieve a balance between the spontaneity and creativity of the nonprofessional and the discipline, responsibility, and scholarship of the professional. If Ortho can make a contribution toward the achievement of that kind of balance in its own membership, it would be one of the most important contributions that could possibly be made.

The discussion was concluded with a plea from the floor that such a crucial issue as this, fundamental to the whole future of Ortho, not be put to a membership vote by mail until some strategy is devised for creating a dialogue with all members to ensure that they have thought through the ramifications. The intricate, subtle, and impassioned discussion at this Business Meeting seemed to make it clear that the Association is not ready to make a decision about modifying its membership requirements. We cannot, summarized one member, hammer through a new membership policy until the whole membership tells us in a much more clear way what it thinks it wants Ortho to become.

NEW BUSINESS

When the meeting was opened for new business from the floor, the following motion was made and seconded:

In view of Ortho's concern regarding the present conflict in Vietnam as expressed in a resolution in 1968, the Board should reassess the implications of contracting for a management study with a known Defense Department contractor and reconsider their decision.

It was also suggested that the use of a management consultant by the Association needed discussion by the membership.

Legal counsel for the Association gave as his opinion that the contract signed by the Board with the management survey firm, Arthur D. Little, was a binding agreement and that the membership body at this Business Meeting could not mandate the Board but could only express its sense to the Board. If the Board should now wish to limit the activity of the management firm, presumably there would be no liability beyond that for the time of the firm's staff that have already worked on the study.

The presenter of the motion, however, stated that he felt that the Resolution on the Vietnam War passed by a mail ballot of the entire membership in 1968 bound the Association to a position which precluded its involvement with an organization involved in activities that the resolution takes a stand against.

Representatives of Arthur D. Little were given the floor to describe the purpose of their study of Ortho and the firm's consulting ethic.

Some members expressed the view that this motion, if passed, would put Ortho in the position of accepting the "guilt by association" theories. Others argued for the motion on the basis of the need to act consistently with the intent of the earlier Vietnam resolution.

After full discussion, the vote was taken: *Motion defeated—51 to 43*. Dr. Prugh indicated that the vote was taken only to get a sense of the point of view of the members present. The members, he said, have expressed a concern that merits Board attention. Though the majority voting opposed the motion, the issue is clearly of enough concern that the Board will give the matter serious consideration.

EXPERT TESTIMONY

It was proposed that, in light of the increasing numbers of mental health professionals being called to give "expert" testimony to congressional committees, that Ortho assume the responsibility of making our views publicly known in order to counteract the impression that one individual's testimony is representative of the entire mental health field. It was also suggested that Ortho should take the initiative to inquire as to how people are selected as "experts" and how members of various Presidential commissions are selected. Dr. Prugh, while agreeing with the seriousness of the problem, raised the question as to how Ortho could usefully act. He asked that suggestions for action be sent to the Board by the introducer of the proposal and other concerned members.

Dr. Prugh introduced the new president, Judge David L. Bazelon, and the meeting was adjourned.

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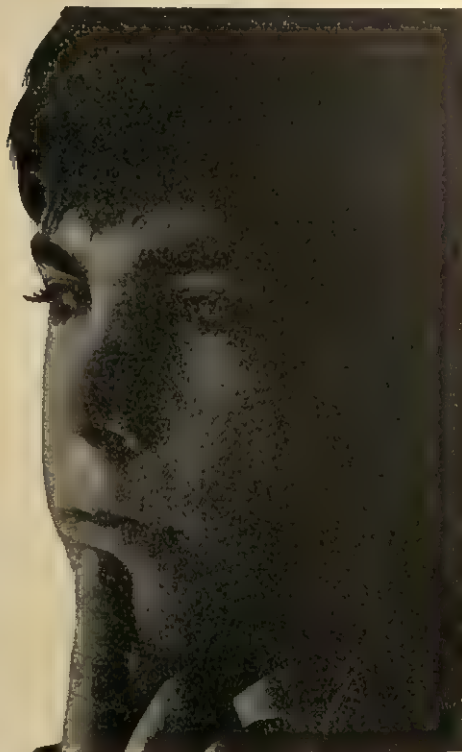
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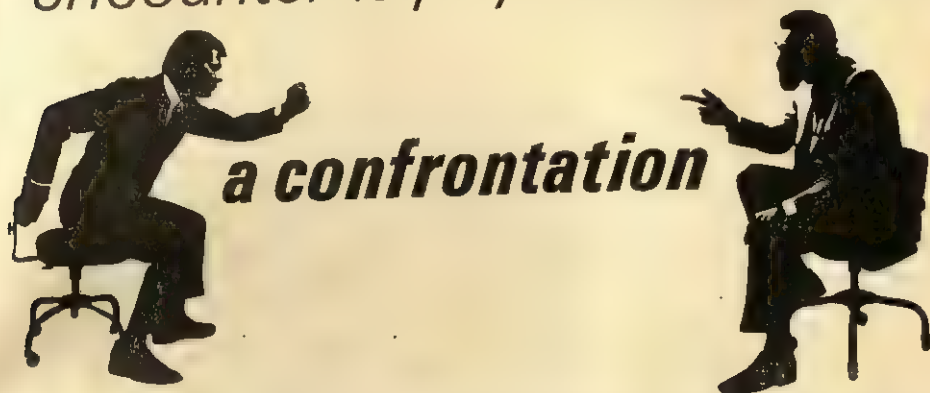
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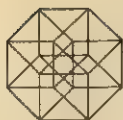
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